			For State Registrar	State of Ma	iryland /		tificate of L			Reg. No.	110	38001
	Dhysisia		1. Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death 2:28 p ^M
	Physicia /Medic	al	SAMUEL RICHARD	HACKETT			41. Oh. T	Leastion of Dooth	NOVEMB		nty of Death	
	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)			Elkton	Location of Death	l	Ceo		
3	^		Union Hospital 5. Social Security Number 6.	Sex 7. Age	(In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	1	9. Birth	place (State or Foreign
	Funeral Director		214-34-9054	-FR	73	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da May 23	1937	Mar	yland
	D		Usual Residence of Decedent									10d. Inside City Limits
	irylan show	_	10a. State 10b. County		10c. City, To		cation					1 ☑Yes 2 ☐ No
	Ba-f	Director	MD Cecil		Cecil	ton	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	with ti	ä	10e. Street and Number	7			21913			U.S.		
	sath v	Funeral	172 Center St.	Apt. 5A	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No		Race - Amer	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it in Medical Event increment by nufficed and once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?			fYes, specify Cuba □Yes 2 No	an, Mexican, Puert Specify:	o Rican, etc.)	can, etc.) Black, White, etc. Specify: Black		
21215-0036	"natura	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give)	lent's Usual Occup kind of work done o OO NOT use retired	durina most of wor	king		Business/Ir	County
12	withir ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Schoo	ol Bus Dr	river		Board	of Ec	lucation
2	Hygi other ent,	Be C	17. Father's Name (First, Middle, Las	şt)				18. Mother's Nan		, Maiden Surr	name)	
au	should be fi and Mental H s marked ot sumatic ever	To B	Walter Hackett					Rosie M				
Maryland	shou and N s ma	-	19a. Informant's Name/Relationship	(Type. Print)	1		ng Address (Street					
	1 and 2 Health a tem 27 is		Tyrone Wilson	(nephew			9 South F		Dr. Do	ver, D	on - City or T	
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Special Contents)	☐ Removal from State			sition (Name of natory or other place nation		6/10		na, DE	
Balti	permit. F Departm Importar any Injur		21. Signature of Funeral Service Lic		M00510	Ga 11	Name and Addre alena Fun 8 West C	ss of Facility eral Homo ross St.	e of Ste Galena	ephen I	Sch. 21635	aech
- 15			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused ly one cause on each lin	the death. D	o not ent	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician Medical		disease or condition resulting in death)	Due to (or as	a consequence	ce of):	12624	anon		A 1		10 ur
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	ce of):	i'c Cor	DIATH	arteri	1 dise	LSP	1094
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	0.0000000000000000000000000000000000000	on of):						
8760,	be ex		resulting in death) East	Due to (or as	a consequent	ce oi).						
876	cate I physia the b	dical		d								
O. Box 6	ath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d	Date of deli Month	ivery Day Y <i>e</i> ar
σ.	that the de		Part II. Other significant conditions	s contributing to death be	ut not resultin	g in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
rds	uires n sign lid be	d by	Carolia sa	cnosi3 9	m-mi	5			15	Yes 2□N	lo 3□ Pr	obably 4 Unknown
Division of Vital Records,	he law requir e has been si tge 2 should l	Completed								opsy ormed?	prior to death?	topsy findings available completion of cause of
ta	an: T tificat tor, pe		25. Was case referred to medical					26. Place of De				
<u> </u>	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ER	/Outpatie	nt 3 🔀 DOA	ner: 4 \(\text{Nursing} \)	Home 5 ☐ Re	sidence 6	Other (Spe	cify)
on o	Attending Ph r death. ector: After th by the funeral	tion: T	27. Manner of Death → Sulvatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da		b. Time o Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe	how injury o	ccurred	
Divis	Il or Atter after dea Director d in by the	Certification: To	3 Suicide 6 Could not 4 Homicide determine	28e. Place of IIII	ury - At home c. (Specify)	, farm, str	reet, factory, office			(Street and Nown, State)	lumber or Ri	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and manner sta	of examination	dge, deat and/or in	th occurred at the the the the the the the the the th	time, date and place opinion, death occ	ce, and due to the curred at the tim	e cause(s) ar e, date and pla	nd manner a ace, and due	s stated. e to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date s	igned (Mont	h, Day, Year)
	- 3-0		1	>	MP		D	005173	35	13	3011	0
			30. Name and address of person will Frederick Delk	oov. M.D.	6602	Churc	Print) Ch Hill R			MD. 21	620	
	Sta Regist	ate rar	31. Date filed (Month, DECar)	6 2010 ^{32. Registr}	rar's Signature	A. ,	parke					

10-09065 Mary Ellen Hall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

lary Eller Flair		1- For State	Certificate o		Reg. i	No.		
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death	av Year	3. Time of Death	
∕ledical Exami		MARY ELLEN	HALL		November 26	6, 2010	0915 hrs	
)		4a. Facility Name (if not institution, give street	nd number)	4b. City, Town, or Location of Dea Prince Frederick	ith	4c. County of Death Calvert		
,		Calvert Memorial Hospital	7. Age (In yrs. last birthday)		Irs 8 Date of Birth (N	MM/DD/YYYY) 9. Birtl	nplace (State or	
Funeral Director		5. Social Security Number 6. Sex		Months Days Hours M	in.	Foreign	^{ntry} WASH. D.C	
Birector		577-64-3005 1 M 2	Xf 65 Y	rs.	APRIL 7	, 1945	WASH. D.C	
ny ny	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits	
nd how s	_	MD. ANNE ARUNDE	L	LOTHIAN			1 X Yes 2 No	
Maryland 28a-f show any d.at once.	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?	
with the Maryland ms 23a or 28a-f sho be notified at once,	ä	136 A. ST.		20711		U.S.A.		
n with ms 23 be.ng	Funeral	11. Mantal Status 12. Wa	s Decedent Ever in U.S. 13. Wined Forces?	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,	
death or ite	Ē	Never Married 2 Married 1	Yes 2 X No			Specify: זודו	T	
s after rral",	2	3 Widowed 4 Divorced if Yes, G or Dates 15. Decedent's Education (Specify only highe		Yes 2 No specify: ent's Usual Occupation (Give kind o	f work done 16	Sb. Kind of Business/Ir	ITE	
2 hour	Completed			most of working life. DO NOT use r				
36 thin 7. than than	g	10		CLERK		RETAIL		
5-0(ed wil flygien other	S	17. Father's Name (First, Middle, Last)		18.Mother's Nar	ne (First, Middle, Maid	den Surname)		
21215-0(136 hould be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f she ric event, the Medical Examiner must be notified at once	å	JOHN FRANKLIN		mg Address (Street and Number of	Y ELLEN	THOMAS	7in Codo)	
	1	19a. Informant's Name/Relationship (Type, Prin					Zip Code)	
alth alth	ŀ	JOYCE O. RICHARDS/SI	20b. Place of Dispo	1 CROOM RD., BRA	Date 2	0c. Location - City or	Γown, State	
Ore ges 1 a t of H t of H		1 Burial 2 Cremation 3 Rem	oval from State crematory or o		20 2010	DIVEDDATE	MD	
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee /				RIVERDALE		
Balt permit. Departu Importi		MM / hamle	M00091 5	Name and Address of Facility HAMBERS FUNERAL 801 CLEVELAND AV	E. RIVER	DALE, MD.	20737	
Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
/Medical	l	Immediate Cause (Final disease a. Hy	pertensive Ather	osclerotic Cardi	ovascular	Disease	Death	
Examine		or condition resulting in death) Due to (or as a consequence of):					
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated						
ed nsit	Exa	events resulting in death) Last Due to (or as a consequence of):					
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	8	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED Due to (c.) Due to (c.) AMEN TRIPEMALE: 23c. 1	DED 23a,27 per me	g910 12-27-10 v	7t			
60, ate be o	ledi	IF FEMALE: 23c.	f yes, outcome of pregnancy			23d. Date of delivery		
587 crifica ling pl	any	23b. Was decedent pregnant in the past 12 months?	Live birth 2 F	Fetal death 3 Ectopic preg	nancy	Month D	ay Year	
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9	Pregnant at time of death 5 (Other (Specify)				
that the dated by the detached	돌	Part II. Other significant conditions contributions		e underlying cause given in Part I.		cco use contribute to		
P.O.	3				1 Yes	2 No 3 Prob	ably 4 V Unknown	
ords, aw requir nas been s 2 should l	Completed				24a. Was an autopsy		opsy findings available ompletion of cause of	
c law e has ge 2 sl	ם				performe	ed? death? No 1 ✓ Ye	s 2 No	
ician: The secrificate rector, page		25. Was case referred to medical		26.Place of Death (Che	ck only one)			
Vita ysicia his cel	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 🗸 ER/Outpatie	nt 3 DOA Other Nur	-	sidence 6 Other	:	
27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 28d. Describe how injury occurred								
Divi ospital or , hours after neral Dir y filled in I		4 Homicide	ne best of my knowledge, death occ	aumod at the time date and place a	and due to the cause(s	s) and manner as state	ed.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the	basis of examination and/or investig	gation, in my opinion, death occurre	d at the time, date and	d place, and due to the	e cause(s)	
To To com	Med	29b. Signature and title of certifier	nner stated	29c. License number	2	9d. Date signed (Mor	nth, Day, Year)	
		Panot Kaull 11 nos	1	O.C.M.E.	1	November 27, 20	10	
		30. Name and address of person who complete	d cause of death (Item 23a)					
		Pamela E. Southall, MD Assis	tant Medical Examiner 1	11 Penn Street, Baltimore	, MD 21201			
	ate	31. Date filed (Morth Et. Y07) 2010	32. Registrar's Signature	arles				
Regis	rar		Museum G. D.	arran				

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ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0713 PM Physician/ November 2010 Harbaugh Irene Rosanna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown County Hospital Washington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 9/19/1937 Maryland 1 □ M 2 🔀 F 73 215-34-3758 Director Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location 10a, State with the Maryland Examiner must be notified at Directo 1 XYes 2 No 28a-f Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral 23a 21740 U.S.A. 11 W. Baltimore St. Apt. 117 tems 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married ò þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify "natural", 3 Divorced Completed Year or Dates Health and Mental Hygiene. iem 27 is marked other than "natui ither traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Medical Clinical Property of the Control of Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ William Patrick Wilson Myrtle Margarette Lowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 927 Summit Ave. Hagerstown Maryland 21740 Department of Health Important: If item 27 any injury or other to Vicky Yates / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 11/29/2010 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave. Hagerstown Maryland 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a on equence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 m onths?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a g ☐ Unknown i signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: / by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after

To the Funeral Direct

Completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

DHMH 17 Rev 7/2009

State

Registrar

only one)

31. Date filed (Mo

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n

Registrar's Signatur

parke

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D06039

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV. 24, 2010 Year Physician 11:30P M FLORENCE RAMONA HARRIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES WALDORF 1208 BANNISTER CIRCLE 8. Date of Birth Month, Day, Year 10-23-1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number WASH., D.C. **Funeral** Days Hours Min 1 M 2 XF 81 578-36-2783 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Mentical Englishment once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State WALDORF 1 ☐Yes 2X No CHARLES MD. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20602 1208 BANNISTER CIRCLE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 🌠 ☐ No Specify: Specify:WHITE þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOCTOR'S OFFICES RECEPTIONIST 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORENCE LENEVE ROFF RAYMOND JOHNSON COOLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STEPHANIE A. ZEHER-DAUGHTER 1208 BANNISTER CR. WALDORF, MD. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition To the Constitution of th 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee M00479 LA PLATA, MARYLAND 20646 (ne 23a. Part 1. Enter the disease, or complicating hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ling physiclan and e as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending to be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Sonknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 ☐ Yes 2 🗆 No 1 □ Yes 2 🕽 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deal Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt) 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 26, 2010 Year Physician/ W. 4:22 PM Dallas Hite Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 439 South Street Cumberland Allegany Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🗆 F Dec 16 MD Director 723-07-9781 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified ** once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland MD 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 439 South Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify WWII Specify: 3 Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) pipefitter Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W.E. Hite Audrey (Kaylor) Hite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 439 South Street Cumberland MD 21502 CaroyIn Hite wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State 11/28/2d10 Cresaptown MD 4 Demation 5 Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility Paral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Internal Between et and Death Immediate Cause (Final disease or condition ₽hysician/) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conclines if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗀 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Mann eath 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) State 06 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. 26, 2010 KATHERINE NORMA HOWARD 2:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS LA PLATA CENTER CHARLES LA PLATA Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD . 212-42-6405 1 M 2 X F 67 Months Days Hours Min. 9-26-1943 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD. CHARLES WALDORF 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3634 OLD WASHINGTON ROAD 20602 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2X Married "natural", or ģ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ Xo Specify: Specify:WHITE 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working CHARLES CO. permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COOK BOARD OF EDUC 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES WILBUR JACKSON NORMA KATHERINE SAFFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. HOWARD-SPOUSE 3634 OLD WASH.ROAD WALDORF, MD. 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD. VETERANS CEM. 12-3-2010 CHELTENHAM, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Annaic beain disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Duc to (or as a consequence of): Examine meumon 10 that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 No certificate 1 Tes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 126/10 D0070900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 1A Annopolis Dr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 Registrar

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		-	For State Registrar	State of Ma		partment of I <i>ertificate of</i>			giene Reg. No		38007
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1	/Medic	al	Christine Marie 4a. Facility Name (If not institution, give	·		4b. City, Town, o	or Location of Dea	ath	2 7 4c	County of Death	1
فرس	Examin	er	6530 Quiet Court			St. Le				Calvert	
	Funeral Director		220 74 3203	ex 7. Age	(In yrs. last birthdo	Months Days			iy, Year)	Cot	nplace (State or Foreign intry) many
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	a-f sh	ctor	Maryland Calvert		St. Le	onard					1 □Yes 2X□No
	ith the	Directo	10e. Street and Number			10f. Zip Code	.05			itizen of What Cou	
	eath v	Funeral	6530 Quiet Court	12. Was Decedent E	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cub		(Specify Yes or No		ted Stat 14. Race - Ame	rican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Proficel Exertifica must be routined at once.	þ	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ∐Yes 2 🕅 N If Yes, Give Year or Dates:	lo	If Yes, specify Cub 1 □Yes 2 No		erto Rican, etc.)		Black, White Specify: Wh	
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Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (*Bryan K. Howe11/H			ailing Address <i>(Stree</i> 30 Quiet ((ip Code)
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altimore,	Page ment c ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			l Veterans				_	
Balt	permit. Departi Import any inj		21. Si nature of Funeral Service Licen	1 1.7	00817	22. Name and Additional Additiona					.H., P.A., 1, MD 20622
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Crani		Oster	Sanco	MA			
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O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				23d. Date of de Month	livery Day Year
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		'	30 Name and address of person who	completed cause of d	leath (Item 23a) (T)	Mourin	me at	Prin	Ce =	Fred.	MI
	Sta		31. Date filed (Month, Day, Year)	- O(- W	ar's Signature	barring		1)	
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AMEND ITEM#23a, pt1,28b&d, perME, G910,12/2/72010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Month 2028 Nov. 11 Physician/ Hinebaugh Tommy Ray Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Garrett Friendsville 198<u>5 Noah Frazee</u> Road 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Dec . 3, 1960 Social Security Number **Funeral** Days Hours 1 X M 2 D F Maryland 49 217-76-977 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County Director 1 ☐ Yes 2 X No Friendsville Garrett MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. Funeral 21531 1985 Noah Frazee Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Timber College (1-4 or 5+) Elementary/Seconday (0-12) Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Staub Margaret P. Hinebaugh Ralph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 271 Short Mile RD., Friendsville, MD 21531 Margaret Hinebaugh/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Blooming Rose place) 1 XBurial 2 Cremation 3 Removal from State Friendsville, MD 11/15/10 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service ocensee 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Contact Shotgun Wound of Head disease or condition resulting in death) Annroximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) SECOVAS Examiner Sequentially list conditions, Due to (or as a nonsequence of) Examine it any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death Year Day Month in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown þ cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No Yes After this certificate 26. Place of Death (Check only one) **Director**: After this certific I in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 2 🗌 No Certificate: To 28d Describe how injury occurred Subject shot self 28b. Time of **1** 2 2 9 M 28c. Injury at 28a. Date of injury (Month, Day, 27. Manner of Death 5 Pending 1 ☐ Yes 2 No 1 Natural 10 Investigation Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be 28e. Pl ce of njury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide determined completed filled in by 185 Noaht Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/11/2010 н 26154 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 69 Wolf Acres Dr., Oakland, MD 21550 DO Miller Daniel 37. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Maryland 21215-0036	hould and N s ma		19a. Informant's Name/Relationship (Typ	pe, Print)		19b. Mailir	g Addre	ss (Street ar	nd Number or R	ural Route Numi	ber, City	or Town, State, Zip	Code) 21797
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	~ ^								uneral Ho	
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Κ	nysic lis ce direc	10	1 ☐ Yes 2 🗶 No	Hospital: 1	ent 2 X]E	R/Outpatier	nt 3 🗆	DOA Other	: 4 Nursing	Home 5 ☐ Re	sidence	6 ☐ Other (Specifi	y)
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injur (Month, Day	y 2 Year) 2	8b. Time of injury		28c. Injury work?		28d. Describe	e how inj	ury occurred	
on	endir eath. or: Af he fu	fica	2 Accident Investigation				М		∕es 2 □ No				
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Ö	italo irsaf al Di					_					,		
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Examin										ed. ause(s) and manner stated
	To the H within 24 To the F complet	₹	only one) 3 Gertifying Nurs				leath occ	curred at the	time, date and p		the caus	e(s) and manner as s	tated.
	To Con		29b. Signature and title of certifier				25	9c. License	number		29d. [Date signed (Month,	Day, Year)
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	8		30. Name and address of person who co	ompleted cause of de									
			Philip G. Henj	um, M.D.			ice_	Phili _I	<u>Drive</u>	- #200,	011	ney, Mary	land 20832
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Loger Hawkesworth VOV 2010 03404M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bulhmore Maryland Medical Center University of 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Rint **Funeral** Birthplace (State or Foreign Country) 216-40-5603 68 Months Hours 59/11/10/11 942 MD Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD Howard Woodbine 1 🗆 Yes 2 🏝 No 10e. Street and Number ò 10f. Zin Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 16292 Carrs Mill Road 21797 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mean 2010. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roger William Hawkesworth Sr. Lillian Ruth Scoville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hawkesworth - Wife 16292 Carrs Mill Rd. Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 11/16/2010 Hanover, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final envsician/ Non-ischemic Cardiomyopathi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Duis to for as a nonsequence of if any leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗹 No Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOV, 12, 2010 1003131566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Baltimore, MD 21201 OLIVER, NORA South Greene

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

32. Registrar's Signature

15 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Esther B. Hill 5:15 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner a If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth **Funeral** Months Min. (Month, Day, Year) 11-19-1915 1 M 2 Hours 215-74-5207 Director West Va Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Wicomico Salisbury 1 Yes 2 No MD. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21804 U.S.A. 719 Jefferson St. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes Give White 3 Widowed 4 ☐ Divorced Completed ear or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental H Lucinda Tyree Daniels Lee Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5602 North Court, East New Market, MD. 21631 Larry Hill Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne, MD. 11-14-1 Andrews Episcolal 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home 21853 M00295 11673 Somerset Ave., Princess Anne, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final Physician/ disease or conductor resulting in death) EREBROVASULAR se or condition Medical Examiner Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. if ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to \$ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Other (Specify) HOSPICE within 24 hours are After this To the Funeral Director. After this မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at To the Hospital or Attending Natural 5 Pending work' 1 Tes 2 No Accident Suicide Investigation Could not be 6 🗌 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year) 2005 2410 id address of person who completed cause of death (Item 23a) (Type, Print) HU som 0 31. Date filed (Month. Day, Year) State

Registrar

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH, G910, 12/2/2010, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6, 2010 2:30A Edward Gaston Hairston November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12716 Murphy Grove Terrace Clarksburg Montgomery 8. Date of Birth (Month, Day Yea March 28, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🛛 M 2 □ F Virginia 80 Yrs 1930 **Director** 228-38-8935 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1X Yes 2 No Virginia Martinsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a 601 5th Street 24112 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced **Black** Completed or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hairston Bessie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20871 1 and 2 s of Health item 27 i Tuwanda Carter - Daughter 12716 Murphy Grove Terrace, Clarksburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Carver Memorial Gardens 11/10/2010 Martinsville, Virginia ²², Name and Address of Facility Molesworth-Williams P.A., Fu 26401 Ridge Road, Dam<u>ascus</u>, 21. Signature of Funeral Service Legislee Funeral Home us, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OPD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed?
Yes 2X No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Daughters Mome examiner? Hospital Other: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending 2 Accident
3 Suicide М Investigation 24 hours after dea: Funeral Director: within 24 hours after des To the Funeral Director completed filled in by th Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Houna, ye 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud; Salem 32. Registrar's Signature State

Registrar

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 14, 2010 19:00 November Johnson Frances Gladys Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthdav) 6. Sex **Funeral** (Month Day, Months Days Hours Min. 577-42-1875 1 □ M 2**X** 1931 Maryland Director May 79 Usual Residence of Decedent 28a-f shov 10b County 10c. City, Town or Location 10d Inside City Limits 10a. State Examiner must be notified at Direct Temple Hills Prince George's 1 Yes 2 No Maryland 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral **23a** 20748 United States 3420 Rickey Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 9 1 Never Married 2 Married African Yes 2 No Yes, Give Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ▼ Widowed 4 □ Divorced Specify: "natural", American Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Ward Attendant Government 12 vears is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Morris Carroll Mary Ellan Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Deer Park Drive Temple Hills, MD 20748 Health a Morris A. Carroll - Son permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Maryland Vet's Cemt. Nov 29, 2010 Cheltenham, MD nature of Funeral Ser 22. Name and Address of Facility Stewart Funeral Home, Inc. ice Lic 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ropiola Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

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1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autopsv obcible this certificate 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 2 XNo ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred in 24 hours after death.

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4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Lædicai Exaiiii	iiei	William Roger Jenkins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D		4c. County of Death	
•		22126 Clipper Drive Great Mills		St. Mary's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		Months Days Hours	Min. 06-07-	.1053 Foreig	untry)Maryland
_		212-66-3542 1 M 2 F 57 Yrs. Usual Residence of Decedent	100-07	1933	- Har y rand
my		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Maryland 28a-f show any dat once.	g	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	Elmer Leroy Jenkins, Sr. Kath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medisal Examiner must be notified at once	٦	Kathleen L. Jenkins, mother 1485 Jewell Road,			
and 2 lealth tem 2 traus		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I as Department of Her Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departure 5 Other Specify: 50. Memorial Gardens 1	2-01-2010	Dunkirk,	MD
it. Partmentrant		4 Donation 5 Other Specify: SO. Mellior Lat Gardens 1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Ba Perm Depa Impo injur		William R Green 8325 Mt. Harmon			20736
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fospie 4 hour funer		29a. Certifier 4 Continued Physician: To the best of my knowledge, death occurred at the time, date and place			
the F hin 2- the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	rred at the time, date a	and place, and due to the	e cause(s)
To Wit	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Manager De Valle O.C.M.E.		November 27, 2	010
		30. Name and address of person who completed cause of death (Item 23a)			
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 21201		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	NOV 30 2010 Deneva B. Sparkel		OU ME	

DHMH 17 Rev 1/2001 OCME 2006

10-09073

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ILLIAM ANCOWSKI 2010 1717 ENNETH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9748 Wichita Avenue Prince George's College Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral Z** M 2 □ F Months Hours 24, 1940 69 Monessen, PA Director 206-32-8089 November Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince George's College Park 1 X Yes 2 No Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 20740 9748 Wichita Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sound and Lighting 10 Audio Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o marked ဂ္ Irene Pohto Joseph Jankowski 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9748 Wichita Avenue, College Park, MD 20740 Susan Jankowski / Wife or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 11/19/2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 19 nset and 7 ath Immediate Cause (Final disease or condition resulting in death) Physician/ 06 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending Natural 2 No 1 Yes within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this population, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) DEFENSE HWY ANNAPOLI, MD 21401 Name and address of person

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 1 6 2010

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** B:40a. Trinita Diane Jackson 2010 Nov.11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thomas More Nursing Facility Hyattsville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Wash. 1 □ M 2 □ F 579-92-2615 4, 1968 Director MAy Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 X Yes 2 No Director r than "natural", or items 23a or 28a-f si Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20002 U.S.A. 1200 North Capitol St., NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Babanç k If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N/A nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11th Disabled 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Carol Cunningham Eddie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 901 New Jersey Ave., NW #206 WDC 20002 Carol Jackson/Mother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-20-201 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 22. Name and Address of FacilityRonald Taylor II FuneralHm 21. Signature of Funeral Service Lic 10583 Middleport Ln White Plains, MD20695 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final M-etastatic Pancheotic Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): burial-1 physician s the burial Box 68760 pe Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death atter for t in the past 12 months?
1 ☐ Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ inferior Vena Cava TUROMBUS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No ANASARCA 24a Was an Ascites autopsy performed?

1 Yes 2 No page 2 s certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: After Division 5 Pending investigation 1 Natural ours after death.

neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L t 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

VOR

November 13 2010

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Mb 4203 Queensbury Rd Hyattsville MB 20781

29b. Signature and title of certifier

State Registrar 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		4	For State	State	of Maryla		artment of H tificate of D	lealth and N Death		giene Reg. No. 🗇 🕫		
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath C	10	3. Time of Death
	Physicia Medic		Cecil Artenni	s Jackson					Month 11	Day 17	Year 2010	6:15a ^M
	Examin		4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City, Town, or	Location of Death		4c. Count	ty of Death	
- /	, 		Dennett Road				0aklan				Garre	
	Funeral Director	111	5. Social Security Number 212–12–8713	6. Sex 1 ★ M 2 □ F	7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 11 12	h v, Year) 1917	9. Birthp Count	lace (State or Foreign ry) MD
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9	ifter de	by	1 Never Married 2 Mar	If You Gi	2 🗷 No		i fes, specily cuba I ☐ Yes 2 🗷 No	n, Mexican, Puerto Specify:	nicari, etc.)	Specif	ack, White, e	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Service	Licensee A	dock	3	2. Name and Addres	ss of Facility Dav				al Home P.A 550
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9	certifi nding use a	In/M	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pregnanc	21/		23d. D	Date of delive	ery
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	the H thin 24 the Fa	Me	only one) 3 Certifyin	g Nurse Practioner	: To the best of	my knowledge,	death occurred at th	e time, date and pla	ce, and due to th	e cause(s) and a	manner as st	ated.
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	,		30. Name and address of persor	who completed car	use of death (Ite	em 23a) (Type, I	Print)			10		/
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylar	•	artment of F tificate of L		d Mental Hy	giene Reg. No. (10	38019
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1.00	Examin	er	4a. Facility Name (if not institution, giv		er)		4b. City, Town, or		eath	4c. Co	ounty of Death	
** *			Holy Cross Hospit 5. Social Security Number 6.		Age (In yrs. I	ast hirthday)	Silver S		Hrs. 8, Date of Bir		tgomery	place (State or Foreign
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	arylan ta-fst ified a	Funeral Director	,	George's		tsvill						1 X Yes 2 ☐ No
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	with s 23a rust b	era	2023 Rittenhouse	Street			20782				USA	
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Division of Vital Records, P.O.	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the	I Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tov		umber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completed filled	Medical		niner: On the basis	of examination	n and/or invest	gation, in my opinio	n, death occurr		and place, and	d due to the ca	use(s) and manner stated.
	To t		29b. Signature and title of certifier				29c. License	number	270		igned (Month,	
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R	25		30. Name and address of person who Suganthi Alagarsa					ilver S	Spring. MT	209	10	
	Stat	е	31. Date filed (Month, Day Year)			and I	, 0.		· · · · · · · · · · · · · · · · · · ·			,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November November Physician/ 2010 11:15 Рм Elizabeth Mary Kaplan Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 09/17/1913ear) Washington D.C. 579-18-3209 97 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Merical Examiner must be notified at any injury or other traumatic event, the Merical Examiner must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Hillcrest Heights Prince Georges Maryland 10f. Zip Code 10e Street and Numbe 10g. Citizen of What Country? Funeral United States 20748 2444 St. Claire Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify. Specify: White 3 √ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Clara King Otis Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2444 St. Claire Drive Hillcrest Heights, Maryland 20748 Frederick Kaplan / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/19/2010 Port Republic, Maryland Chesapeake Highland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. 4405 Broomes Island Road Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PSIS disease or condition resulting in death) Medical Examiner 771798(4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Yes 3 No Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 death? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 뎯 1 🔲 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 11:05 PM Kenneth Martin Karrer November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Lutheran Village Westminster 8. Date of Birth (Month, Day, Year) Sep 5, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Yrs. Director 90 048-22-2413 Iowa Usual Residence of Decedent shov the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f si notified 1 Tes 2 X No Ellicott City Maryland Howard 10e. Street and Numbe 10f. Zip Code ቮ 10g, Citizen of What Country? ral", or items 23a o Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. 3020 N. Ridge Road W - 13321043 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married XYes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates. 1938-1946 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Guidance Counselor Balt. Co. Public Schools æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Martin Karrer Vesta Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3020 N. Ridge Road W-133 Ellicott City, MD 21043 Rhoda Dahl Karrer/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/16/2010 Woodbine, Maryland re of Funeral Service Licen M00957 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HISHEIMEN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the a detached f is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by • Hospital or Attending Physician: The law requires 124 hours after death.
• Funeral Director: After this certificate has been sign 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed 2 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Hospital: Other: 1 Tes 2 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rayuwiya, MD 51705

Registrar

State

DHMH 17 Rev 7/2009

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ddress of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 29c per DVR G910 12/9/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 7:15 A Patsy Lee Kaufman November 28, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19902 Bloomfield Court Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 F 3/24/1934 Maryland 220-28-2838 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, "he Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19902 Bloomfield Ct. 21742 U.S.A. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any illury or other traumatic event 9008. Be Weddle Gift Chester н. Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Kaufman / Daughter 19902 Bloomfield Ct Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 11/30/2010 Hagerstown Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses J. Wa 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rcho /Medical Due to (or as a consequence Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a consequence of): Examine The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) غارج) جارج المجانبين Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 2 - Mo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes 3 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Sick 2 100 2 No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes this ၉ s after death.

I Director: After this of in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D38968 24 N. Walnut st 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

DUMIN 17 HeA 1/500.

10-08807 Keith Arden Kamp Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	-	20 Name or deddess of a	who completed as	no of death	(Item 23a)									
		 Name and address of person Donna M. Vincenti, MI 				111 F	Penn Street	t, Baltin	nore, MD	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#8.PerFHPQC11-30-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1125 2010 Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 24 Hrs. 8. Date of Birth Min. July Gonth, Day, If Under 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 💢 F Director City, Town or Location 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Mental ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other traunonce. dorf. Mb 20640 Momas 20b. Place of Disposition (Name of Metrock)

Metrockist Country (Name of Metrock)

Metrockist Church Lemeters 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 20/2010 Indian Head, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Greene Funeral Home, INC Signature of Funeral Service License St. Alexandria, VAZZ314 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennsylvania Ave NW - Washington 31. Date filed (Month, Day, Year) State NOV 1 9 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MARIE 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KENT CHESTERTOWN STREET YNCH BURG Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. **Funeral** Months Days 1 ☐ M 2 🔀 🔻 8-20-01 Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 Yes 2 No KENT Director CHESTERTOWN Mn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21620 112 NLYnCHBURG STREE Funeral Pages 1 and 2 should be filed within 72 hours after death itent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23. 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc I □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 BLACK Completed by 3 Widowed 4 □ Divorced er than "natur, the Medical R 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CHESTERTOWN BANK CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRATCHER BRATCHER ၉ 19a. Informant's Name/Relationship (Type. Print) 12ALG HTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trau once. 205 N. LYNCH BURG STREET CHESTERTOWN MO JACQUELINE GONZAL E2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/30/2 1 Burial 2 □ Cremation 3 ☐Removal from State HURLOUL, MO ETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) BERNIE SMITT FUNGRAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 855 HIGH CHESTERTOWN, MO21620 STREET Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): ancer /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐Yes 2☐No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 11 10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 NO 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-13/3 10/26/10 Mun, m)

State Registrar 31. Date filed (Month

Chestertown MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vashington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) Month 11 Physician Vernon Lipscomb 06 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02–24–1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1**X** M 2□ F Months Hours Illinois 345-14-1748 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director PG Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 USA 12424 Sadler Ln. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McCree Rosetta George Lipscomb ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Lipscomb/Son 12424 Sadler Ln. Bowie MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Pk Crem. 11-11-2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH Signature of Funeral Service Licensee Promot 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner attending physician and for use as the burial-trar resulting in death) Last Division of Vital Records, P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ∏Yes 2 □No detached 9 Unknown 9 Unknown s been signed by should be detach 23e Did tobacco use contribute to the cause of death? þ Be Completed certificate has page 2 After this certific funeral director, Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deat To the Funeral Director: filled in by the completely

art II. Other significant conditions of	orthopating to death but not re-	20c. Dig tobacco doc della lodio to the dado of death.										
Acuta Kano	I Failur	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown										
Matabolie 1	autopsy prior to completion of cause of											
Throm 60 cys	topenia			performed death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No								
25. Was case referred to medical	/		26. Place of De	ath (Check only one)								
examiner? 1 ☐ Yes 2 ② No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ D	OA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manns of Death 1 Manual 5 □ Pending 2 □ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street, factor	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
				ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)								

State

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

0551

X Yes 2 No

Approximate Interval Between Onset and Death

Day

Year

son who completed cause of death (them 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland / Depa			and M	lental Hy	giene		38027
			Registrar 1. Decedent's Name (First, Middle	o / act)	Cei	rtificate of [Death			Reg. No.		00021
Phys			_	ittlejohn					2. Date of De Month	Day	Year	3. Time of Death
Me S Exa	dic.		4a. Facility Name (if not institution			4b. City, Town, or	r Location o	of Death	Щ	20	ab O	2a', a5 M
			Prince Georg	ges Hospita	a 1	Cheve:						Georges
Fune			5. Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
Direct			578-21-4378 Usual Residence of Decedent	,	19 Yrs.				June	8,199	1 Was	sh.,DC
land show		Ē	10a. State 10b. County		10c. City, Town or Lo	cation				a ne	1	0d. Inside City Limits
Mary 28a-f		Director	MD	PG	Capit	ol Heigh	hts					1 Yes 2 No
h the		a D	10e. Street and Number			10f. Zip Code				10g. Citizen	of What Cour	try?
ms 2;		Funeral	919 Capitol			207				Unite	ed Sta	ates
or ite		by F	11. Marital Status1 Never Married 2 Married Mar	12. Was Decedent I Armed Forces? 1 Yes 2		Vas Decedent of Hi f Yes, specify Cuba	spanic Orig n, Mexican,	in? (Spec Puerto F	ify Yes or No- lican, etc.)		Race - Americ Black, White, e	
O36 Is after		ed b	3 Widowed 4 Divorced	153/2- 0'- X	1	☐ Yes 2 X No	Specify:			Spec	Blac	L
21215-0036 within 72 hours after giene. ier than "natural", o t, the Medical Exami		Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Deced	lent's Usual Occupa	ation	of working			f Business Inc	
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d 2 Hygie other ent, ti		ωŀ	10 17. Father's Name (First, Middle, L	ast)		Cashie		de Nieuwe	/		peyes	
lan lental fental rked tic ev	ŀ	의	John Little				Ani		(First, Middle, McJor		ame)	
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event	54.1	J	19a. Informant's Name/Relationsh		19b. Mailin	g Address (Street a	and Number	or Rural	Route Numbe	r, City or Towr	n, State, Zip C	ode)
	1		Earthlen Lit	tlejohn/gr		919 C	apit	ol F	leight	s Bly	d.	1
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	1	- 1	20a. Method of Disposition 1 → Burial 2 — Cremation	3 Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place		$\frac{c_1}{2/3}$	ate I	20c. Locatio	on - City or To	wn, State
Itim it. Pag rtmen rtant: njury		-	4 Donation 5 Other (S	pecify)	Harmony		l Pa	rk			lover,	
Baltimol permit. Page 1 Department of Important: If i any injury or or	ouce	ļ	21. Sign ture of Funeral Service Li	icenses		Name and Addres						
		\dashv	23a. Part 1. Enter the disease, or	complications that caused	the death. Do not ente	10 Silv					and, M	
~ Physicia	ij.		Immediate Cause (Final	inly one cause on each line		•				001		Approximate Interval Between Onset and Death
Medic	al		disease or condition resulting in death)		consequence of):	arini	busar	Wa	مرم			
Examin		-	Sequentially list conditions	AID	S							
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5/6U ficate b g physias the b	120			d								
ords, P.O. BOX 68, v requires that the death certific been signed by the attending should be detached for use as	Dhyeioion/M	2	F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2 Fetal death 3	Ectonic pregnancy	,			23d. I	Date of deliver	y
box death of the atter		2	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at	time of death 5	Other (specify)				1	Month I	Day Year
at the deby the detact			Part II. Other significant condition	ns contributing to death bu	ut not resulting in the un	iderlying cause give	en in Part I		02a Dida			
S, T	1	2			and the same	adinying daddo give	arm runt i.		1 🗆 Y		_	cause of death?
required shoul	100								24a. Was a			sy findings available
ding Physician: The law requires th. After this certificate has been significate in the control of the control	Completed	-						_	autop: perfor	sy med?	prior to com death?	pletion of cause of
// (a) Fician: T	8		5. Was case referred to medical examiner?			26. Plac	ce of Death	(Check o	1 Yes	2 No	1 ☐ Yes 2	? Lano
hysic hysic his ce	F	<u> </u>	1 ☐ Yes 2 ☑ No		nt 2 ER/Outpatient	3 DOA Other	4 🗆 Nurs	sing Hom	e 5 🗆 Reside	ence 6 🗆 O	ther (Specify)	
ding Pl	j	2	7. Mann of of Death 1 ☑ Natural 5 ☐ Pending			28c. Injury : work?		- 1	d. Describe ho	w injury occu	irred	
Attendir r death. ctor: Af	Certificate:		2 Accident Investiga 3 Suicide 6 Could no	ot be	y - At home, farm, stree		es 2□N					
alor / safter			4 ☐ Homicide determin	building, etc.	(Specify)	et, ractory, office		28	f. Location (St City or Towr		iber or Rural F	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificath within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Medical	2	29a. Certifier 1 Certifying F	Physician: To the best of n	ny knowledge, death oc	cured at the time, of	date and pla	ace, and	due to the cau	se(s) and mar	ner as stated	
the H hin 24 the Fi	Me		only one) 3 Certifying	caminer: On the basis of ex Nurse Practioner: To the b	amination and/or investig	ation, in my opinion	death occu	irred at th	e time date an	diplace and d	lue to the cour	e(s) and manner stated
고 # 교 전 교		2	9b. Signature and title of certifier	0. m	n	29c. License r			2	9d. Date sign	ed (Month, Da	ay, Year)
			K. Bros		U	000	491	83		11/91	110	
		1	0. Name and address of person wi	no completed cause of dea	11 11 1	_	Che	Vor),,	In .	7/170	5
	ate	3	1. Date filed (Month, Day, Year)	32. Registrar	's Signature	01-	Ore	7 4	(4)	MD.	2010	
Regist	rar		DEC 0 6	2010 Janen	n B. A.	alled						

DHMH 17 Rev 7/2009

BHMH 17 Rev 7/20

J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14, 2010 3:30 November Marie Langley Helen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Dameron 50176 Dove Cove Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6 Sex 7 Age (In vrs. last birthday) **Funeral** Months February 28, 1935 Maryland Director 75 218-58-1971 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No **Maryland** Dameron St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral USA 20628 50176 Dove Cove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Food Service Manager should be filed with and Mental Hygien is marked other ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Greenwell Jeanette A. Ernest Matthew Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau MD 20628 Peggy L. Erdolino / Daughter 50176 Dove Cove Road, Dameron, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 18 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Great Mills, Maryland Holy Face Cemetery 2. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee Jara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔯 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes n 24 hours after death.

In Funeral Director, After the pleted filled in by the funeral funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 💆 Natural 5 \square Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 the only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD 20636 MD., James Patrick Jarboe, bay, Year) 31. Date filed (Month, State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:00 PM Thelma Janis November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** 36140 Aviation Yacht Club Road St. Mary's Mechanicsville 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** . Social Security Number 1 🗆 M 2 🏝 F (Month, Day, Y Months Hours Year Country) 81 Yrs. Director 213-38-3017 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Mechanicsville St. Mary's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36140 Aviation Yacht Club Road 20659 USA death 1 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home Be Department of Health and Mental Himportant: If item 27 is marked of any injury or other traumatic over-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna Mae Hardesty Wilfred Rencher Hardesty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 36140 Aviation Yacht Club Road, Mechanicsville, 20659 Janice Pilkerton / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 30. cemetery, crematory or other place)
Christ Episcopal Church 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 2010 Chaptico, Maryland 4 Donation 5 Other (Specify) Cemetery Signature of Funeral Service Licer 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed h 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital 1 ☐ Yes 2 No ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 잍 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural injury 5 Pending after death.

Director: Aft 1 Yes 2 🗌 No Accident Investigation the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2

State Registrar

29b. Signature and title of certifie

Jennifer Merry Schmidt,

30. Name and address

31. Date filed (Month, NOV)

DHMH 17 Rev 7/2009

of person who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

D.O.

2 3 2010

H0055

40900 Merchants Lane, Ste. 205, Leonardtown, MD 20650

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 5:00 A Linnenbrogger 7, 2010 Russell George November 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Frostburg Frostburg Village Nursing Home 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/26/1928 7. Age (In yrs. last birthday) 5. Social Security Number Days Months Maryland 1 X M 2 □ F 82 212-24-1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 □ No Cumberland Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 13301 Winchester Road, SW, Box A-16 21502 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 No Korean
If Yes, Give
Year or Dates: F.na 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify White ģ 3 ☐ Widowed 4 ☐ Divorced Era 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Be Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tire and Rubber Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Porter Mae Eva Linnenbrogger Christian William ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), MD 19a. Informant's Name/Relationship (Type. Print) 13301 Winchester Road, SW, Box A-16, 21502 Peggy J. Linnenbrogger / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/11/2010 Cumberland, MD 22. Name and Address of Facility ams ami y unera ome, . . . 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 21502 404 Decatur Street, Cumberland, MD OLOK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6months Immediate Cause (Final Advanced disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 T Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2XNo 1 ☐Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 8, 2010 D0055325 womochs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wonsock Shin, M.D., 925 Bishop Walsh Road, Cumberland, MD

54 MAS State

To the Hospital within 24 hours a To the Funeral Completely filled

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatith and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

= 5 permit. Page: Department o Important: If i any Injury or once.

Physician

/Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year)

Wonsock Shin, M.D., 32. Registrar's Signature

NOV 08 2010

Registrar

Leon

1. Decedent's Name (First, Middle, Last)

Roscoe

Physician

Approximate Interval Between Onset and Death PULMONARY FIBROSIS 6 MES 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 12 No 2 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mx Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0014865 November 15, 2010 leted cause of death (Item 23a) (Type, Print) 200 Glenn St, Suite 302, Cumberland, MD21502 Jr., M.D., ORIGINAL

State

31. Date filed (Month, Day, Year) NOV 15 2010 Registrar

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who comp

6 Could not be determined

Robustiano J. Barrera, 32. Registrar's Şignature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Lantz

2. Date of Death

Day

14.

2010

Allegany

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Race - American Indian,

Black, White, etc.

Fire Department

20c. Location - City or Town, State

LaVale, MD

Day

3. Time of Death

7:04

9. Birthplace (State or Foreign Country) West Virginia

White

21502

10d. Inside City Limits

1 XYes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 27, Physician/ 2010 2130 PM Myrtle Marie Loller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Care and Rehabilitation Center E1kton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days June 24. Year) 1915 1 □ M 2 💢 F Maryland 220-14-5478 Director 95 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No E1kton Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 Price Drive 21921 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker and Mental Hygien is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alonzo Allen Mary Jackson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Grayson Avenue, Apt. 207, Chesapeake City, MD 21915 James E. Loller/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 3 cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Paul's Cemetery 2010 4 Donation 5 Other (Specify) Earleville, MD 22. Name and Address of Facility Hicks Home for Funerals, F.A. Sign ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ DEMENTA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Divito lar as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier P. V. Nonge D0069733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 126 A E. HIGH STREET, ELKTON, MD 21921 RAO V. PULA

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November John Francis Lawrence TT 2010 1345 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mount Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 6, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 1 🕱 M 2 🗆 F Months 54 1956 Washington DC Director 217-70-6812 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland Director Woodsboro Maryland Frederick 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21798 U.S.A. 11402 Coppermine Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) f Health and Mental Hygiene. item 27 is marked other thai Newspaper/Media Photographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ဂ္ Hilleary Margaret Mary John Francis Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 14503 Westbury Rd, Rockville, Maryland 20853 John F. Lawrence, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If its
any injury or or 1 Burial 2 X Cremation 3 Removal from State Nov 17,2010 Smithsburg, Maryland Smithsburg Crematory: 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Keeney & Bastord P.A. Funeral Home M00706 106 E Church St. Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CLEAR RENAU CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: KUNE HOUSE 1 Tes 2. KNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 6 Other (Specifi this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗌 No 24 hours after death.

Funeral Director: A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. date and place, and due to the cause(s) and manner as stated. (Check within 2 3 🗌 only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D31761 November 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

State

Brian O'Connor, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2010

501 West Seventh St, Frederick, Maryland

10-087	34
Marlon	Murphy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marion Murphy	1- For State	State o	f Maryland /		ment of icate of		d Mental		2 () Reg. No.	10	38036		
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)							2. Date of De	ath	ear	3. Time of Death		
Medical Examine	MARLON MI 4a. Facility Name (if not institution, give street and number)				JRPHY 4b. City, Town, or Location of Death				er 14, 2010	y of Death	1538 hrs		
_ /		Johns Hopkins Bayveiw Medical Center Baltimore							y or Bodin				
Funeral	5. Social Security N	5. Social Security Number 6. Sex 7. Age (In yrs. la			ast birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.			N. Com	•	(Y) 9. Birt	hplace (State or WASHINGTON		
Director	577-72-9144 1XM 2_F 56				Yrs. Molitis Days Hours Min. OCT.				31 1954	Col	intry) DC		
any	Usual Residence of 10a. State	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town					or Location						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	WI	WI				LWAUKEE				1 XYes 2 No			
	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country								itry?				
ith the 123a o	6629 N 9	6629 N 9th STREET 11. Marital Status 12. Was Decedent Ever in U				.S. 13. Was Decedent of Hispanic Origin? (Specify Yes				USA or No- 14. Race - American Indian, Black,			
leath w	1 Never Marri	Table 1 Amend France 2					erto Rican, etc.)						
s after or rall, or rall, or F	3 Widowed	3 Widowed 4 Divorced If Yes, Give Year or Dates:			1 Yes 2 No specify:				Specify: BLACK				
2 hours "natu Exam	15. Decedent's Ed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of	dusiness/li	ndustry		
5-0036 ed within 72 hour yygiene. other than "natu the Medical Exan Completed	1	2TH					CASTER			PRIVATE			
filed w filed w I Hygie of othe		17. Father's Name (First, Middle, Last)			18.Mother's Name (First, N								
21215-0036 total be filed within 7 d Mental Hygiene. Is marked other than ite event, the Medica TO Be Comple								Zip Code)					
MD d 2 sho fth and n 27 is rumati	DELORES	MURPHY/WI	FE					MILWAUKE					
ore, eslan of Hea If iten	20a. Method of Dis 1 Burial 2	position Cremation 3	Removal from State		ce of Dispositi natory or othe	on (Name of cer r place)	- 11	Date	20c. Location				
Baltimore, bernit. Pages I an Department of He important: If ite		Donation 5 Other Specify: 21. Signature of Funefal Service Licensee									1 LANDOVER, MARYLAND NKINS FUNERAL HOME, INC.		
Bal Depa Impo	21. Signature of Fu	A LICENSE									LAND 20785		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and			
	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of): b. b.								Death				
iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
ted Insit													
60, tre be executed hysician and e burial - transit	d. VINPENDED AMENDED 27, part II, per ME G911 1/11/11 MAM 23d. Date of delivery 23d. Date of delivery												
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the rest this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transicial Certification: To Be Completed by Physician/Medical Existence of the property of the completed by Physician/Medical Existence of the property of the completed by Physician/Medical Existence of the completed by Physician of	IF FEMALE:		23a, 2/, 23c. If yes, outcome	part of pregnan	II, pe ^{cy}	r ME G9	11 1/1.	I/II MAM	23d. Date	of delivery	l		
D.O. Box 6876 that the death certifical ned by the attending phetached for use as the by Physician/IV	23b. Was decedent past 12 months	pregnant in the ?	1 Live birth Pregnant at tir	me of death	- =	I death 3	Ectopic pre	gnancy	Month	D	ay Year		
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Division of Vital Records, F spital or Attending Physician: The law requires tours after death. reral Director: After this certificate has been sign filled in by the funeral director, page 2 should be Certification: To Be Completed 1	24a. Was an 24b. Were aut								opsy findings available				
Records, The law requires ficate has been sig	autopsy prior to c performed? death? 1 ✓ Yes 2 No 1 ✓ Ye								ompletion of cause of				
tal Recian: The certificate ector, page	25. Was case reter						of Death (Che		2				
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should bartification: To Be Completed	1 ✓ Yes	2 140	spital: 1 Inpatient		/Outpatient			rsing Home 5	Residence 6	Other			
nding and or the fune fune fune fune fune	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No												
Visic or Atte ter dea birectol in by th	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rur									al Route Number, City			
Division o Hospital or Attending 24 hours after death. Funeral Director: Aft redy filled in by the funeral of	4 Homicide determined (Specify)												
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
To the within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo												
	Yameh (Withell mi)				O.C.M.E.				November 15, 2010				
₹ ` `	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
State	24 2 4 61 1 61		32. Registrar				.,	,					
Registra	= เมกบว	n zuiu /	endered II	. 100	-								

State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:52P 2. Date of Death Physician/ LAMIKA CAMILLE MARSHALL Novem Medical 4a. Facility Name (if not institution, give street and number) Location of Death 4b. City, Town, 4c. County of Death **Examiner** Medica Lata harle LAF enler If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🙀 F Months Days Hours Min OCTOBER 331° ar) 1984 MARYLAND 26 216-15-0193 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No POMFRET CHARLES MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral UNITED STATES 20675 8340 WARREN DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married 1 Yes if Yes, Give 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12TH GRADE College (1-4 or 5+) CONTRACTOR CONTRACT SPECIALIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY ESTHER WILLIAMS KELVIN NATHANIEL MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8340 WARREN DRIVE, POMFRET, MARYLAND MARY E. WILLIAMS / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State NOV. 19, 2010 LA PLATA, MARYLAND SACRED HEART CHURCH 4 ☐ Donation 5 ☐ Other (Specify) 21 Senature of Funeral Service Licens 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions in any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi mo been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical con Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 L Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe 1 Yes 2 No After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient မ 1 Yes 2 ER/Outpatient 3 DOA Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation hours after death uneral Director; / Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29h. Signature and title of certific 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kd. Woldorf Nirmaladevi 32. Registrar's Signature State NOV 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore 9. Birthplace (State or Foreign County) irginia If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Months 228-30-6031 1 □ M 2 💢 F 83 October 10, 1927 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Charles Bel Alton 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9265 Crain Highway 20611 USA 'natural", or items 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 😾 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Manager Apartments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked ob any injury or other framment ၉ Conrad Hicks Naomi White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Conrad Marsh/Son 670 Kensington Ave. Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Felts Cemetery 11/15/2010 Galax, Virginia M00945 21. Signature of Funeral Service Licensee Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, PA. Cchi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 1 Yes 2 = 9 Unknown the detached Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has performe certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB10 31. Date filed (Month, Day, Year) 32. Registrar's Signature **NOV 17** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death / Month **Physician** 04569 M November 2010 VERONICKA P.K. MARX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMBRIDGE DORCHESTER GENERAL HOSDITAL DORCHESTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 1 F Director 7/15/1918 **NEW JERSEY** 137-12-1646 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "had all Examines must be notified at 1 ☐ Yes 2 X No Director **CAMBRIDGE** DORCHESTER MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 5020 RIPPLING ROAD 21613 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. ģ 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) land 2121 Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING LAB TECH 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ **BLASIS KOCHIS** VERONICKA UR altimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5020 RIPPLING RD., CAMBRIDGE, MD 21613 JOHN BUCK, JR. / SON-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 Dother (Specify) NEW BRUNSWICK, NJ 12/1/2010 ST. PETER'S CATHOLIC CEMETERY 21. Signature of Funeral S 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consi Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of) Box 68760, certificate be Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 Dav in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No P.0. the detached 9 Unknown 9 🗀 Unknown ģ signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Teas 1 ☐ Yes 2 ☐ No icate has been signated by page 2 should b 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? or Attending Physician: The certificate 2 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 28a. Date of Injury (Month, Day, Year) After this c 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/200

State

Registrar

ORIGINAL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 ▶

32. Registra 's Signature

Wownier

DEC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oly a Liselottie I		1- For State Registrar 1. Decedent's Name (First, Middle, Last		ertificate of		no Mental	R	201 eg. No.	0 88041	
Physici Medical Exami		01	Lieselotte	Melton			2. Date of Dea Month Novembe	Day Year r 28, 2010	3. Time of Death 0001 hrs	
		4a. Facility Name (if not institution, give Washington County Hospi	•		b. City, Town, o	or Location of Dea		4c. County of De Washingtor		
Funeral Director		5. Social Security Number 6. Se 093-34-5675	77	last birthday) Yrs.	If Under 1 Ye Months Da			th(MM/DD/YYYY) 9. 9, 1937	Birthplace (State or Foreign Country) Germany	
nd show any ice.	_	Usual Residence of Decedent 10a. State 10b. County MD Washingt		y, Town or Location Hagersto					10d. Inside City Limits 1 Yes 2XX No	
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 21842 White Oak	Road		10f. Zip Code 21 7	740	1	Og. Citizen of What C Germany	17. 1	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Extininer must be notified at once	by Funeral		ever Married 2 Married Armed Forces? 1 Yes 2 X No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No 1 Yes 2 X No specify:							
9036 vithin 72 hour iene. er than "natu Medic 4 l'x at	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	's Usual Occupa ost of working life emaker	of work done etired)	Own home			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	o Be Co	17. Father's Name (First, Middle, Last) JOSEf 19a. Informant's Name/Relationship (Ty		rwein	Address (O)	Maria		•	Haimerl	
MD 2 id 2 shou ulth and 1 m 27 is n	ř	Helmut John Fri	ck - Son	21848	White	Oak Road	d, Hagers	stown, MD	21740	
Baltimore, permit. Pages I an Department of Hea Important: If ite		20a. Method of Disposition 1 Burial 2XX Cremation 3 Donation 5 Other Specify:	Removal from State Ha	Place of Disposit crematory or othe gerstown	er place) 1 Cremat	ory 12	Date 2/2/2010	20c. Location - City Hagersto		
		21. Signature of Funeral Service Licens	M0052	1 95	Union	Street	Rerkeles	Home, Inc. Springs,	WV 25411	
Physician /Medical -xaminer		_	cations that caused the death h line. fultiple Injuries tue to (or as a consequence o		e mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
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ed	Examiner	cause. Enter Underlying Cause	ue to (or as a consequence of							
50, te be executed ysician and burial - transit	Medical	d. UNPENDED	AMENDED as noted	,G910,12	/27/201	0.WS				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Me	3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	nancy 2 Feta	al death 3	_	nancy	23d. Date of delive Month	ery Day Year	
O. Bo	된	1 Yes 2 V No 9 Unknown Part II. Other significant conditions	9 Unknown	esulting in the un	derlying cause o	given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?	
S, P.C	ed by								obably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law requirs after death. In Director: After this certificate has been sted in by the funeral director, page 2 should law to be the funeral director, page 2 should	Completed						24a. Was a autops perform	sy prior to med? death?		
Vital Ro	ě	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient		of Death (Check Other: Nursi		Residence 6 Oth	er:	
ion of trending Pt leath. tor: After the funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Mouth, Day, Year) Nov 27, 2010	28b. Time of Inju 2319 hrs	·	ry at Work? Yes 2 ✔ No		ow injury occurred a auto that struck	parked vehicle	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Certification:	3 Suicide 6 Could not be determined	28e Place of Injury - At h		factory, office b	ouilding, etc.		treet and Number or F ate) d, Hagerstown, Md.	Rural Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a and manner stated.	ge, death occurre	n, in my opinion	, death occurred	d due to the cause at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)	
		29b. Signature and little of certifier	Teek ME	34	29c. Licens			November 28, 2		
		30. Name and address of person who co Victor Weedn MD JD Ass	mpleted cause of death (Item sistant Medical Examir		nn Street, B	altimore, MD	21201			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire) Bar	RA					

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		_	For State Registrar	Stat	e of Marylar	•	artment of F tificate of L	Health and M Death		ene g. No. 201(3804
п	D		Decedent's Name (First, Mi	iddle, Last)					2. Date of Death		3. Time of Death
, and	Physicia Medic		Gertrude	М.		Morris			Mov 2	28, 2010 Year	5:00 AM⁴
	Examin	er	4a. Facility Name (if not institu 51 Maple S		f number)			r Location of Death Derland		4c. County of Death Allegany	/
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		place (State or Foreign
	Director >		521-26-9103 Usual Residence of Decedent)	⁻ * 86	Yrs.			iviay i	3, 1924	ND
	s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	ctor	10a. State 10b. Cou	Allegany	10c. C	ity, Town or Lo Cu	mberland				10d. Inside City Limits 1 □ ¥Yes 2 □ No
	the Ma or 28a e notif	Dire	10e. Street and Number				10f. Zip Code		10	Og. Citizen of What Cou	
	th with ns 23a must b	Funeral Director	51 Maple S					21502		USA	
ဖွ	er deat or iter miner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐	Arme Married 1 □	Decedent Ever in U ed Forces? Yes 2 No			lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
003	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted	3 Widowed 4 Divor	rced Year	s, Give or Dates.		Yes 2 No				/hite
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lanc	should be filed within 72 hours afti and Mental Hyglene. is marked other than "natural", aumatic event, the Medical Exar	To E	Frank We					18. Mother's Name Kathe		elten) Weisz	
Maryland 21215-0036	should and N is ma raumal		19a. Informant's Name/Relati Bonnie Mann	onship (Type, Print)	daught	19b. Mailir	ng Address (Street	and Number or Rural	Route Number, G	City or Town, State, Zip	TN 37615
	permit. Page 1 and 2 should be filed within 72 hour. Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. once.		20a. Method of Disposition	9	20b.	Place of Dispo	sition (Name of	! .		Y 20c. Location - City or Ti	
Baltimore,	Page 1 ment of ant: If i		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth		from State S	cemetery, cren carpelli F	uneral Hon	ne, P.A.	11/29/2010	Cresapto	wn MD
Balt	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Servi	ice Licensee		22	Name and Addre	Seff Fullyeral H	ome, PA	and, MD 21502	
			23a. Part 1. Enter the disease shock, or heart failure. L	, or complications	that caused the dea	th. Do not ente					Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	as to my one cause to	Trche	mic	R I	\sim			Operand Death
-	Medical Examiner		resulting in death)	Du	e to (or as a consec	quence of):	nten.	i Syn	25		2.RS
H	n ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Du	e to (or as a consec	quence of):	10/-02/	230,000			Cy /
	be executed iician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Du	e to (or as a consec	quence of):		***	-		
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687	ertifica ding ph se as th	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes	s, outcome of pregn	ancy				23d. Date of deliv	001
Box 68760	death c e atten ed for u	siciar	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 🗆	Live Birth 2 Fei Pregnant at time of Unknown		Ectopic pregnand Other (specify)	су		Month Month	Day Year
P.O. I	at the o	Completed by Physician/Medio	9 Unknown Part II. Other significant con			sulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ls, P	uires th n signe ald be c	ed by								s 2 No 3 Pro	
of Vital Records,	aw req as bee	nplet							24a. Was an autopsy	prior to co	psy findings available empletion of cause of
I Re	n: The I ficate h or, page	Con	25. Was case referred to med	ical			06 DI	loop of Doobh (Chao)		death?	2 🗌 No
Vita	nysicia iis certi directo	To Be	examiner? 1 Yes 2 No	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatier	Oth	lace of Death (Check er: 4 ☐ Nursing Hor		nce 6 Other (Specifi	()
n of	ding Pt h. After th funeral	ate:	27. Manner of Death 1 Natural 5 Pe	ending	Date of injury Month, Day, Year)	28b. Time of injury	28c. Injur work M 1 \square	y at ⟨? Yes 2 □ No	8d. Describe how	v injury occurred	
Division	er deat ector: by the	ərtific	3 Suicide 6 Co	estigation ould not be termined 28e. [Place of Injury - At h	ome, farm, str				eet and Number or Rura	l Route Number,
Ο̈́	pital or nurs aft eral Dir illed in	sal Ce					4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 -		City or Town,		-
	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the topical directors.	Medical Certificate:	(Check 2 Medic	al Examiner: On th	e basis of examination	on and/or invest	igation, in my opinio	on, death occurred at	the time, date and	e(s) and manner as state place, and due to the ca ause(s) and manner as s	use(s) and manner stated.
	To the within		29b. Signature and title of cer	Wer / NIV	2010	10	29c. Licens	e number	01 29	d. Date signed (Month,	Day, Year)
)		30. Name and address of pers	son who completed	cause of death (Iter	n 23a) (Tvpe. F	Print)	ノナムー	0) /	wembe	4/201
			GARY WAGOI	NEZM.C	0. 925 F	BISHOP	WAISH	RD. a	im BE	PLAND, M	D 21502
	Stat Registra		31. Date filed (Month, Day, Yea DEC 06	2010	32. Registrar's Signa	ature Sark				, -	
				-		17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ricky Lee McNabb 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day November 19, 2010 0943 hrs **Medical Examiner** Ricky Lee McNabb 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Waldorf 1170 Business Park Drive If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Country) 217-90-4525 1 xM 2 F 49 08/16/1961 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 x No Calvert Lusby hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 靣 774 Lazy River Road 20657 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 x No Yes 1 Yes 2 No specify: White 4 Divorced If Yes, Give Year Specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Real Estate Real Estate Agent 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Be Norman McNabb Nancy Limerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McNabb/Mother 774 Lazy River Road, Lusby, MD 20657 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/27/2010 | Washington, DC Olivet Cemetery Mt. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Pineral Service Licenses Lee Funeral Home Calvert, P.A. Blvd.. Owings. MD 20736 Southern Md Blvd., Owings. isa M. Mounts 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line (Martina) Death Narcotic (Herion) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED attending physician or use as the burial AMENDED 27, 28a-f per ME G911 1/11/11 MAM certificate be 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Vital Be Hospital: 1 In patient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division of 27. Manner of Death or Attending Natural unk. 1 Yes 2 X No 5 Pending fd.11/19/10 Director: Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 6 X Could not be 3 Suicide 1170 Business Park Dr. Waldon (Specify) hotel room determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 20, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#8.PerFHPGC11-19-10cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 2010 8:47 BERTHA GERALDINE MCLEAN Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Thomas More Nursing Home Prince George's Hyattsville 8. Date of Birth 10-14-28 9. Birthplace (State or Foreign (Month, Day, 10-17) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours North Carolina 1 M 2 K F 218-26-1501 82 **Director** Usual Residence of Decedent show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Adelphi Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 USA 2012 Pelden Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 😾 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Widowed 4 K Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Laundress 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe Margie Brooks John Buie 1 and 2 should be the Health and Merel the 1 item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14205 Royal Force, Silver Spring, Maryland 20904 Ronnie McLean - Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State 11/19/2010 Adelphi, Maryland George Washington Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ WITE MUSCHENOTIC CONO resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -trans Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical sion of Vital Records, P.O. Box 68760 as 1 by the attending tached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes ∠ 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available coller 24a. Was an prior to completion of cause of death? has performed? After this certificate 05 Twe 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be To the Hosp. or Atterwishin 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Hatsuille My 2019 State 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 38044 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:30 PM Irvin Clay Murray, Jr. November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) District of Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 **№** M 2 □ F Days (Month, Day, Year) 86 Yrs. Director 578-38-9516 November 15. Columbia "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The Marylantist if item 27 is marked other than "natural", or items 23a or 28a-f sho amountant it item 27 is marked other than "natural", or items 23a or 28a-f sho amountant it item 37 is marked other than "natural", or items 23a or 28a-f sho amountant in a marked other than "natural", or items 23a or 28a-f sho amountant in a marked other than a marked othe 10c. City, Town or Location Director 1 Yes 2 X No Hollywood St. Mary's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24940 Half Pone Point Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) Land Development 12 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Irvin Clay Murray, Sr. Doris Hedges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys C. Murray / Wife 24940 Half Pone Point Road, Hollywood, MD 20636 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 6, 4 Donation 5 Other (Specify) Maryland Veteran's Cemetery 2010 Cheltenham, Maryland 21. Seture of Funeral Servicest icense 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 promer 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the funeral director, page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 2 100 1 Tes Yes Be (25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital 0 1 Impatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha L. McLellan Month November 2ďľb P.M Medical 12:42 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Island Solomons Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country) District f Columbia 8. Date of Birth 1 □ M 2X F Months Days Hours Director 578-12-7201 91 Yrs November 3,1919 Usual Residence of Decedent 28a-f show 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified Calvert Solomons 1 Yes 2 K No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11750 Asbury Circle, Apt. 112 20688 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? by Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify 3₺ Widowed 4 □ Divorced Completed Specify: White ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Telephone Operator Telecommunication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2.

Jf Health and
4 item 27 is marke.

Traumatic ev ပ Thaddeus S. Hess Emma Rittenhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaddeus Stevens Hess, III/ Nephew 15275 Hatton Landing Drive Newburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State November 22. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2010 Signature of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. lichae Tardine P.O. Box 270 Leonardtown, Maryland 23a. Part | Enter the disease, or c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 9,1416 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Vac Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ⚠ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy this certificate 2 🗌 No Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XWo 2 Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death e Hospital or Attending Pi 124 hours after death. e Funeral Director: After the leted filled in by the funeral Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital 24 hours a To the Hosp within 24 ho To the Fune completed fi

3altimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

State Registrar

DHMH 17 Rev 7/2009

only one 29b. Signature and title of certifie

Joseph John Barth,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III.

NOV 2 3 2010

M.D.

32. Registrar's Signature

00 522 4

110 Hospital Road, Ste. 310, Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 22, Herman Thomas Morgan 2010 4:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 27045 Three Notch Road St. Mary's Mechanicsville 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Hours (Month, Day, Year) Director 83 Yrs. 579-30-9012 September 14,1927 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland St. Mary's Mechanicsville 1 Tes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 27045 Three Notch Road 20659 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry United States Elementary/Seconday (0-12) College (1-4 or 5+) 8 Government Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Morgan Dollie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Michael Jerome Barrett /</u> Son 22180 Knight Court, Lexington Park, MD 20653 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State November 29, 4 Donation 5 Other (Specify) Queen of Peace Cemetery Helen, Maryland 2010 21. Signature of Funeral Service L 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 XJardi 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Coronary arten disense disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by a bstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 1 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 been signed by the should be detached page 2 s has hours after death. Ineral Director: After this funeral completed filled in by the 24 hours a

Page 1 and 2 should be filed within 72 hours after death with the Maryland

d Mental Hygiene. marked other than

of Health and Nitem 27 is ma

Baltimore, Maryland 21215-0036

State

Medical Escrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D69017 come 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Karen L. Bauer, MD, 28103 Three Notch Road, Ste. 101, Mechanicsville, MD 20659 31. Date filed (Month, 32. Reg

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 7/2009 Accident
Suicide

4 Homicide

29a Certifier

Investigation

Could not be

determined

Amended items 1 - For State of Maryland / Department of Health and Mental Hygiene Amended items 4 - \$\frac{For}{State}\$ \$\psi20a\$, 20b, per F.H,11/\frac{E-Tiffcate}{E-T}\$, WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. D2010 12, David Maizel 12:27 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12436 West Torquay Rd Ocean City Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F 7/107 1937 wash. DC **Director** 73 217-34-2434 Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes X No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 USA 12436 West Torquay Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Ves 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify:white 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor commercial construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sam Maizel Mary Plotkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Gregg Maizel (son) 915 Parkhill Road Laurel, MD 20707 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott First ysteracte or Cher place)
King David Mem. Card Millsboro, DE Falls Church, VA 1 Burial 2 X Cremation 3 - Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Faneral Service Altensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ wono arten disease or condition **Medical** resulting in death) Examiner 0 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performe this certificate 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at work? After 5 Pending 1 Yes 2 No Accident filled in by the Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nov. 12, 2010 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 11107 Racetrack Berlin, MD 21811 State NOV 1 5 2010 Registrar

	4	For	State of Ma	aryland / D	epartment of l Certificate of	-lealth and M <i>Death</i>		ene	38048
		Registrar 1. Decedent's Name (First, Middle	a (ast)		Och imodio of		2. Date of Death		3. Time of Death
Physicia	ın	Albert	, Lasty	Morgan,			November		5:43 A M
/Medic Examin		4a. Facility Name (If not institution	, give street and number)	- 0		or Location of Death Cumberlan	d	4c. County of Deat	egany
		Western MD Reg	ional Medica	l Cente				9. Birt	hplace (State or Foreign
Funeral		5. Social Security Number 218–16–2752		e (In yrs. last birt	Yrs. Months Days		8. Date of Birth (Month, Day, 12/09/1	Year) Co	cyland
Director	-	Usual Residence of Decedent							10d. Inside City Limits
/land		10a. State 10b. County		10c. City, Town					1 □ Yes 2 XNo
Mary Inc.	ż	MD Alle	egany	I	LaVale			og. Citizen of What Co	ountry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene, the Maryland sther than "netural", or items 23a or 28a-f show ent, the Mydical Exacting must be positived at	Director	10e. Street and Number 17 Roselawn	Avenue		10f. Zip Code	21502		USA	
s 238	Funeral		12. Was Decedent	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
ter de iner	F.	11. Marital Status 1 ☐ Never Married 2 ☑ Mar	Armed Forces?	No 1943-	1 ☐ Yes 2 🛱 No		o racan, c.c.,	Specify:	
urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 163 2 X	opouny.		16b. Kind of Business	White
2 hou	ted	15. Deceder	nt's Education est grade completed)	16a	Decedent's Usual Occi (Give kind of work don)	e during most of wor			
thin 7 an "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retir	ea)		Tire and	Rubber
ygier ygier rer th	ខ	12	Local			18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	Harragna
be filk ntal H ed oth	Be	17. Father's Name (First, Middle, Albert	H.	Moi	rgan	Ada	Rebecca		Howsare
hould nd Me mark matic	ျှ	19a. Informant's Name/Relations	ship (Type. Print)	198	o. Mailing Address (Stre	et and Number or Ru	ural Route Number	r, City or Town, State,	Zip Code)
nd 2 s lith ar 27 le rtrau		Rosellen Morga	n / Wife		o. Mailing Address (Stre 7 Roselawn			20c. Location - City o	Town State
f Hear f Hear fitern othe		20a. Method of Disposition		20b. Place of cemete	of Disposition (Name of ery, crematory or other p	lace)		LaVale,	
Pages lent o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐ Removal from State Specify)	Restl	awn Mem. Ga	rdens 11/	12/2010	· ·	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examination in the modified 21 ence.		21. Signature of Funeral Service	Licensee		22. Name and Add	dress of Facility AC atur Stree	et, Cumbe	rland, MD	21502
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		shock, or heart failure. Lis			with Medica				Onset and Death
Physician /Medical		disease or condition resulting in death)	- a.	as a consequence					
Examiner			h						
7 +	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequence	e of):				
ecuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence	e off.				
ficate be executed physician and the burial-transit	Ě		Due to (or a	as a consequence	5 0,7.				
cate be e	dical		d						
box oc eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcon	ne of pregnancy				23d. Date of	
death certificate e attending physic for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnan	h 2□ Fetal dea It at time of death				Month	Day Yeer
at the de	IVS	9 Unknown	9 Unknow				220 Did t	obacco use contribute	e to the cause of death?
/ision of Vital Records, F.O. Attending Phyelcien: The law requires that the reath. sctor: After this certificate has been signed by the tyneral director, page 2 should be detache.	by P		itions contributing to death	h but not resulting	in the underlying cause	given in Part I.			Probably 4 🔀 Unknown
of VItal RECOTCI Phyelclen: The law require r this certificate has been si and director, page 2 should b							24a. Was	an 24b. Were	autopsy findings available
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r VItal Koyelclen: The is certificate he director, page	Ö					00 Division of D	1 ☐ Yes eath (Check only o	-74	′es 2□No
VITAL P Iclen: Th certificate rector, pag	a	25. Was case referred to medi- examiner?			Outpatient 3 DOA			idence 6 ☐ Other (5	Specify)
Physe this al dir	P	1 X Yes 2 No 27. Manner of Death	28a. Date of (Month,		b. Time of 28c.	Injury at Work?		how injury occurred	
On Of ding Phye h. After this funeral di	į	1 Natural 5 Pen	ding (Month, stigation 10/24/	<i>Day, Year)</i> / 2010	Injury AM M	work? 1 □Yes 2 🔀 No		nt fell at	
Division or Attending after death. I Director: Afte	Cartification: To	2 ☑ Accident IIIVe 3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ald not be 28e. Place of		, farm, street, factory, off	fice	28f. Location (City or To	(Street and Number of wn, State) 17 Ro	r Rural Route Number, Oselawn Ave
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			fying Physician: To the becal Examiner: On the bas and manne	sis of examination	dge, death occurred at t and/or investigation, in	my opinion, death o	ccurred at the time	, date and place, and	due to the cause(s)
To the H within 24 To the F complete	Modical	one) 29b. Signature and title of cert		, stated.	29c. L	cense number		29d. Date signed (M	
7 viit 50		230. Orginatoro and into or both	0 /r~	No of the last of		D09157		Novemb	er 9, 2010
++		30. Name and address of pers	son who completed cause	of death (Item 23	Ba) (Type, Print)		ND O	1502	
noll		Paul Snow	, M.D., 121	4 W. Thi	rd Street,	Cumberlar	id, MD 2	1502	
5	State	B4 Date filed (Month Day Ve		gistrar's Signature	parket				
Regi	etrai	1401 1	- LUIU XXX	1-	(1)				

10-08932 John Edward M	assi		pe or Print i							.egib	le.	38049
		1- For State Registrar	,		rtificate of				70	Reg. N	Street Or 2	3 30042
Physici Medical Exam		Decedent's Name (First, Mid John	dle,Last) Edward		Massie	· III			2. Date of I Month Novem	Death	y Year	3. Time of Death 1802 hrs
3		4a. Facility Name (if not institut Washington County		umber)		b. City, Towr Hagersto		cation of Deat	h		4c. County of D Washington	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	\rightarrow	If Under 24Hr		Birth (M	M/DD/YYYY) 9.	Birthplace (State or reign
Director		216-02-2394 Usual Residence of Decedent	1XM 2 F	32	Yrs		Days	Hours Mir	Oct.	15,	1978	Country)Maryland
any		10a. State 10b. County	/	10c. City	, Town or Locati	on						10d. Inside City Limits
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Mary r 28a ed at	Director	10e. Street and Number				10f. Zip Coo	de			10g. C	itizen of What (Country?
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after d	by Fu	3 Widowed 4 D	1 Yes		1	Yes 2X	No s	specify:			Specify:	White
ours a		15. Decedent's Education (Sp	ecify only highest gra	de completed)	16a. Deceden			(Give kind of O NOT use ret		16b	. Kind of Busine	ss/Industry
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens from "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12 10) College (1-4 or 5+)	Labor	_	ine. Di	O NOT use rec	ned)		Roofing	
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121 d be fi lental arked	Be.	John E. Massi	-		T 401 14 111			Barbara		_		
D 21 should I and Mer 7 is man	To	19a. Informant's Name/Relation Kara Massie/Wi						nd Number or e, Shai			City or Town, Si	_
mnd 2 sho lealth and tem 27 is traumati		20a. Method of Disposition		20b.	Place of Disposi			_	Date			or Town, State
MOFe, Pages I ar tent of Her ant: If ite		1 Burial 2 X Crematic		om State	crematory or oth							
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760, ficate be exe g physician at the burial -	/Me	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes,	outcome of pregi	nancy					23	3d. Date of deliv	•
OX 687 eath certific	cian	past 12 months?	I I Trace	irth ant at time of de	oth -	al death er (Specify)	3 📙	Ectopic pregna	ancy		Month	Day Year
Box 68760, e death certificate be the attending physicied for use as the buried buried for use as the buried f	Physician/Medica	1 Yes 2 No 9 Un			5 ∐ Oth	er (Specify)						
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - trans	Ē	Part II. Other significant condi	tions contributing to	death but not re	esulting in the ur	derlying caus	se giver	n in Part I.		_		to the cause of death?
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of \ ig Phy fler th	۵ خ	1 Yes 2 No 27. Manner of Death	28a. Date (Month		28b. Time of In		njury at	t Work?	_		jury occurred	
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Division of Vital Records, ppital or Attending Physician: The law requir nearal Director: After this certificate has been stilled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Cou	la not be	e of Injury - At ho	ome, farm, street	, factory, offic	e build	ing, etc.	28f. Location or Town		and Number or	Rural Route Number, City
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Silvent Silvy	hysician: To the bes	of examination ar								
T W W G	Me	29b. Signature and title of certific	and manner si	iaieu.		29c. Lice	ense nu	ımber		29d.	Date signed (A	Month, Day, Year)
		anist				0.0	C.M.E	Ξ.		No	vember 22,	2010
	ŀ	30. Name and address of person										
			sistant Medical E	1	111 Penn St	reet, Baltir	more,	MD 21201				·
Sta Regist		31. Date filed (Month, Day, Year)	6 2010 32. Rg	strar's Signatu	P. 40	ake						
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10-08982 Mi≎hael Anthon	у Му		rpe or Print itate of Mary	land / Depa	rtment				giene	egible.	010	38050
Physici Medical Exam		1. Decedent's Name (First, Midd Michael	dle,Last) Anthony	Муе	rs				Date of De Month Novembe	ath	Year 10	3. Time of Death 0613 hrs
)		4a. Facility Name (if not institution 1504 Accokeek Road		number)		4b. City, Tov Waldor		tion of Death		Pri	county of Deat nce George	e's
Funeral Director		5. Social Security Number 213-06-3479	6. Sex	7. Age (In yrs. Ia) If Under Months		Under 24Hrs. lours Min.	8. Date of B	•	Foreig	rthplace (State or gn Georgia buntry)
ryland a-f show any Lonce.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prin 10e. Street and Number	nce George		Town or Lo	cation	ode			10a Citize	n of What Cou	10d. Inside City Limits 1 Yes 2 X No
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036 thin 72 hours ne. than "natu tedical Ex m	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		(1-4 or 5+)	during		ng life. DO N	Give kind of wor NOT use retired			of Business/	Contractor
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Ex. miner must be notified at once		1 X Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	Specify:	from State C	y land	other place) Vet. (2. Name and Ac	Cem .	12/2/	e P.	Chel Kalas	tenham Funer	, Maryland
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. Card :	iac Arry	Do not ente	er the mode of o	lying, such	as cardiac or re	espiratory an	rest, shock	, or heart	Approximate Interva Between Onset and Death
ed sait	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as	a consequence of):							
0, be executed sician and urrial - transit		X UNPENDED	d. X AMENDED	6 per fl	h 23a,	,27 per	me g	911 1-2	0-11			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medica	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?	he 1 Live	nant at time of dea	2	Fetal death Other (Specify		topic pregnancy	y		Date of delivery Conth E	/ Day Year
S, P.O. I	è	Part II. Other significant condit	tions contributing t	to death but not re	sulting in the	a underlying ca	use given ir	n Part I.	1 Ye	s 2 N	lo 3 Prot	the cause of death?
Record The law rec ficate has bee	Completed						S. (2		1 ✓ Yes	osy rmed?		topsy findings available completion of cause of
Division of Vital Records, P.O. B within 24 hours after death. To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	n: To Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatie	ent 3 DOA	. Injury at W	Vork? 28			e 6 Other	: Scene
Division Hospital or Attendi 24 hours after death. Funeral Director:	Medical Certification:	3 Suicide 6 Coul	ding estigation	ce of Injury - At ho	me, farm, st		Yes 2		f. Location (or Town, S		Number or Ru	ral Route Number, City
To the Hospit within 24 hour To the Funers	dical Ce	29a. Certifier 1 Certifying Pl	hysician: To the beaminer:On the basis	st of my knowledge of examination an								
● * * * 3		29b. Signature and title of certified Partial Turker 30. Name and address of person	er N. MD		23a)		C.M.E.	ber			esigned <i>(Mor</i> nber 24, 20	
		Pamela E. Southall, M		Medical Exan		111 Penn Si	treet, Bal	ltimore, MD	21201			

State Registrar 82. Registrar's Signature

			Please	State of Maryla					_	ible.
		•	For State	State of Maryla	•	tificate of l			Reg. No.	10 38051
			Registrar 1. Decedent's Name (First, Middle, Last))				2. Date of Dea		3. Time of Death
	Physicia Medic			ERIC VAN	GAR	TH MAGAI	HA	Month Novembe	er 28	Year 2010 1:15 A M
	Examin		4a. Facility Name (if not institution, give s				r Location of Deat	h	4c. County	
-1			Frederick Memori	al Hospital		Frede				lerick
	Funeral		5. Social Security Number 6. Sex 217-56-1782	7. Age (<i>In yr</i> s XM 2 □ F 60	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		Year/950	9. Birthplace (State or Foreign West) Virginia
	Director		Usual Residence of Decedent	1			 	ridy 15	, 1550	West Vilginia
	and show	힏	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	Maryl 28a-f otifie	iec	Maryland Frederic	CK	Middle	town				1 ☐ Yes 2X No
	h the a or	밀	10e. Street and Number 10 Eastern Circ	10		10f. Zip Code 2176	69		10g. Citizen of V U.S.A.	Vhat Country?
	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed by Funeral Director			10 110 1					
	r dea or ite	Y.	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		e - American Indian, k, White, etc.
036	s afte ral", c Exan	g pe	3 ☐ Widowed 4 🏋 Divorced	1 Yes XXNo If Yes, Give Year or Dates.	1	☐ Yes 2XX No	Specify:		Specify:	White
2-0	hour natu dical	olet	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	pation during most of wo	rkina	16b. Kind of Bu	siness Industry
2	hin 72 ne. than '	mo.	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	NOT use retired)			Hardwa	re/Supplies
7	d wit Hygiel ther	Be C	17. Father's Name (First, Middle, Last)	3	Dai	es birec		me /First Middle		
ano	be file ental l ked c c eve	10	Marvin Glenn Ma	gaha			Hele	me <i>(First, Middle, I</i> n Hef li n	naiden Gamame	/
Maryland 21215-0036	12 should be filed within 7 aith and Mental Hygiene. 27 Is marked other than ir traumatic event, the M		19a. Informant's Name/Relationship (Typ		19b. Mailir	g Address (Street	and Number or Ru	ural Route Number S Drive,	City or Town, S	tate. Zip Code)
Σ	and 2 sl Health a tem 27 l		Daniel V. Magaha	, son	15043	Savannal	h Height	s Drive,	Austin,	78717
ore	of He If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	20b.	Place of Dispo	sition (Name of natory or other plac	ge) D	Date 3, 2010	20c. Location -	City or Town, State
Baltimore,	t. Pag tment tant: jury c		4 Donation 5 Other (Specify)	,						derick, MD
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service sicense		$0255 \begin{vmatrix} 22 \\ 1 \end{vmatrix}$	Neemegdre 06 East	æntfa⊞asf Church S	ord PA Fi t., Frede	uneral H erick. M	lome 1D 21701
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hm.	Physician/		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	canc	710				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a conse		<u> </u>				
	Examiner	<u>ب</u>	Sequentially list conditions,	b						
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9289	or Attending Physician: The law requires that the death certificate is the death certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the line.	Nedi								
99 ×	endin r use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregi 1 Live Birth 2 Fe		Ectopic pregnan	су			te of delivery
Вох	the att	Physician/Med	1 Yes 2 No	4 ☐ Pregnant at time o g ☐ Unknown	f death 5	Other (specify)			Mor	nth Day Year
P.O.	es that the des signed by the s be detached f		Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
S, F	ires that signed d be del	d by						1 🗆 ነ	′es 2 □ No	3 Probably Unknown
ord	require been si should	lete						24a. Was a		Vere autopsy findings available
Sec.	The law ate has page 2:	Completed						autop perfor 1 🗆 Yes	med? d	orior to completion of cause of leath?
a F	sician: The certificate rector, pag	Be C	25. Was case referred to medical			26. P	lace of Death (Che		ZGINO	103 Z 10 NO
Κ	hysici nis ce I direc	To E	examiner? 1 Yes 2 No	lospital: Inpatient 2	☐ ER/Outpatier	t 3 🗆 DOA Oth	er: 4 Nursing I	Home 5 Resid	ence 6 🗆 Othe	r (Specify)
οl	ing Pl	ate:	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	ζ?	28d. Describe ho	ow injury occurre	d
ior	ttend death tor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home form stre		Yes 2 No	29f Location (S	troot and Numbo	er or Rural Route Number,
Division of Vital Records,	after after Direc		4 ☐ Homicide determined	building, etc. (Spec		cet, factory, office		City or Town		7 Of Fideat Fidule Fideribes,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical		cian: To the best of my kno						
	the Ho hin 24 the Fu mpleter	Mec	only one) 3 Certifying Nurse	er: On the basis of examinate Practioner: To the best of	non and/or invest my knowledge, o	leath occurred at th	ne time, date and pl	ace, and due to the	cause(s) and ma	
	Vith vith Con Con		29b. Signature and title of certifier	un N	71	29c. Licens	e number			(Month, Day, Year)
J			Fauzi (Kizvi	MD	000	IMDI	8160 C	V	www	ber 29, 2010
			30. Name and address of person who co Fauzi Rizvi, Mr	ompleted cause of death (life	St 7	th Stre	et, Fr	rederick		
	Stat	te	31. Date filed (Month, Day Year) 0 3	400 We	nature &	1		· · · · · · · · · · · · · · · · · · ·	_	
	Registra	ar	MEC () O	LUIU Cleven	U 1.	garre				

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov 27, 2010 10:45 PM McElfresh S Hannah 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Moran Manor Health Care Center Westernport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 20, 1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2□£ 220-16-5427 98 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 □ Yes 2 □ No MD Westernport Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21562 25701 Shady Lane USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 □**X**io 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ **X**o Specify: 3 □Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leland Benjamin Kessel Mary Alice (Calhoun) Kessel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Sommer grandaughter 628 Kamalu Road 96746 HI Kapaa 20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/30/2010 MD Flintstone 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1. shock Immediate Cause (Final ORDINARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery □Ectopic pregnancy Month Day Year ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24

Physician /Medical Examiner

death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

filed within 72 hours after death Hygiene.

"natural",

and 2 should be filed within 72 hour aith and Mental Hygiene.
27 Is marked other than "natural er traumatic event, the Medical E.

of Health

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

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/Medical

Examine for use as the burial-trans attending physician Physician/Medical s been signed by the þ Completed page 2 After this certificate has funeral director, Be

esuiting in death) Last	Due to (or as a consequence of):
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 5

	1 Tyes 2] No	3 ☐ Probably	4 Nnknowr
	24a. Was an autopsy performed?	24b.	Were autopsy fi prior to complet death? 1 ☐ Yes 2 ☐	ion of cause of
26. Place of Death	(Check only one)			

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at/ Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

n 31. Date filed (Month, Day Registra's Signature

State Registrar

Certification:

Medical

death.

To the Hospital or Attence within 24 hours after death To the Funeral Director:

filled in by

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ JAMES 2306 M EVGENE NOV MORRIS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Yes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) Funeral 1 🔯 M 2 🗆 F Days Hours Director 205-22-0188 Sept. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3429 Jay Dr. 21042 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

X Yes 2 □ No 1951 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2x No Yes Give 3 Widowed 4 Divorced Completed 1954 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 5 Analvst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James W. Morris Nellie M. Wingrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant; If item 27 is 3429 Jay Dr., Ellicott City, MD 21042 Joanne Morris / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. Gdns. Nov. 17, 2010 Marriottsville, MD 21. Signature Fun Servi M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 DUX 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death SEPTIC Immediate Cause (Final SHOCK Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEUMOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k ģ ATHEROSCLERATIC CARDIOVASULAR AGENCE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? KIDNEY FAILYRE 24a Was an has CELLULITIS page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 D No |요 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 2010 MOV 15 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lane Howar egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 9, 2010 9:08 p M James Twilley Malone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30523 Fox Chase Drive Wicomico Salisbury 7. Age (In yrs. last birthday) 5. Social Security Number If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days 11777771914 Maryland 95 Director 577-03-2144 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 30523 Fox Chase Drive 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes Give white "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) certified public accountant accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Twilley Malone Beatrice Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 148 Thurman Rd., Beaufort, NC 28516 S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert A. Malone/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Allen Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11?12?2010 Allen, MD 4 Donation 5 Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASCUD Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events Atrial Fib resulting in death) Last attending physician a for use as the burial-Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this an example ted filled in by the funeral di 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047094 NIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-DIVISION Sheet 1415 VI 32. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2010 6:30 Peter Nails November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Clinton Bradford Oaks Nursing Home Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral 1 🕱 M 2 🗆 F Months Days Hours Min. (Month, Day, Year Country 94 Sept. Director Georgia 266-26-0032 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 ☐ No Washington DC 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 2 3518 6th Street 20032 United States death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 'natural", Completed 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4th Auto Mechanic Private Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Jeannie Farmer Thomas unk and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is 20772 Cathy Nails - Daughter 13908 Courtland Lane Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State November 18 4 Donation 5 Other (Specify) Harmony Landover, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. uneral 20019 4001 Benning Road NE Washington, DC 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Altherosclerotic Cardiovascular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed After this certificate I 2 No 2 🕱 N 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 🔼 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes death. 2 🗆 No Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Micahel Sidarous

31. Date filed (Month, Day

NOV16

D45365

11701 Livingston Road Suite #101 Fort Washington, Md. 20744

November 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 Carlito Dizon Nazal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21729 Cabot Place St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 09/05/195 1 X M 2 | F Philippines Director 216-88-0354 57 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Tyes 2 X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21729 Cabot Place 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ¥ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Filipino injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waste Water Management Waste Water Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hermenegildo Nazal Engracia Dizon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07604 Ottawa Ave, Apt. E-8, Hasbrouck Heights, NJ <u>Leila Nazal/Sister</u> 474 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of h Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre 11/23/2010 Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth MO1521 955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Party disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred s after dea... ral Director: After 5 Pending injury work 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar William D.

Boyd,

M.D

32. Red

25365 Point Lookout Road, Leonardtown,

20650

MD

			For State Registrar	State of M	arylan	-	irtment of <i>tificate of</i>			giene Reg. No.	promote (38057	
	Physicia	an/	Decedent's Name (First, Middle	, Last)					2. Date of De		Year	3. Time of Death	
	Media	cal	Ola MI	VALE					Novem	ber 11	, 2010	1720 P ^M	
ار	Examir	ner	4a. Facility Name <i>(if not institution,</i> Allegany Health		Rehab	Ctr.		or Location of Dea erland	ith		nty of Death Allega	ny	
I	Funeral Director		5. Social Security Number 214-07-2861	6. Sex 1 ☐ M 2 ☒ F	e (In yrs. I: 98	ast birthday) Yrs.	If Under 1 Year Months Day			th 1912	g. Birthp Mary	olace (State or Foreign try) 'Iand	
	nd now	Ž	Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Loc	ation				1	0d. Inside City Limits	
	Marylar 8a-f s tified	Director	MD All	egany		Cumb	erland					1 🗆 Yes 2 🔀 No	
	s 23a or 2	Funeral Di	10e. Street and Number 11304 De Have	n Road, NE	•		10f. Zip Code	21502		10g. Citizen o	. Citizen of What Country? USA		
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Marri 3 ※ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.		If	/as Decedent of Yes, specify Cu ☐ Yes 2 🌠 N	Hispanic Origin? (Span, Mexican, Puello Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, e cify:		
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/land	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, L Henry	Washington		Ford		18. Mother's Na Franc	ame (First, Middle, Ces	Maiden Surna	Golde	en	
, Man	id 2 shoull saith and ? n 27 is m a er trauma		19a. Informant's Name/Relationsh Colvin Athey /			19b. Mailin 11304	g Address (Stree De Have	n Road, l	NE, Cumbe	r, City or Town erland,	, State, Zip C MD 2	200e) 21502	
Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation Donation 5 □ Other (S	3 ☐ Removal from State	C	emetery, crem Inset M		Park 11/		Cumb	on - City or To erland	, MD	
Balti	permit. Departr Importa any injt		21. Signature of Funeral Service L		Home, P.A. 21502								
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	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as	a consequ	ence of):	rast	nagia					
	icate be executed physician and sthe burial-transit	al Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):							
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Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	Ectopic pregna Other (specify)	псу			Date of delive Month	ery Day Year	
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			Registrar 1. Decedent's Name (First, Middle, Last)		00	Timeate of E)Catr	2. Date of Deatl		3. Time of Death
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	Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign intry)
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e,	and 2 s Health sm 27 ther tra		Ronald Nair 20a. Method of Disposition	son	Ob. Place of Disp	94 Miss T			tinsburg 20c. Location - City or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Dogation 5 ☐ Other (Specify)	I	cemetery, cre Restlawn	matory or other place Memorial G	ardens	11/30/201	•	MD
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Division of Vital Records, P.O. Box 68760	l or Atter after des Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - a building, etc. (Sp		reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examin	cian: To the best of my ker: On the basis of examin	nation and/or inve	stigation, in my opini	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D3¥8, 2010 **Physician** November 4:30 AM Audrey Lenora Nesline /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Feb. 6, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex ^{Year)} 1926 **Funeral** Days 1 □ M 2 🕱 F Months Hours Feb. 84 Director 234-38-8385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b County ral", or items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 □ No Director Grantsville MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21536 USA 891 Dorsey Hotel Rd. permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23 and Injury or other traumatic event, the Medical Expriner must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Brenneman Lawrence Buckel ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10778 Bittinger Rd., Bittinger, MD 21522 Larry J. Nesline/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 20, 2010 Bittinger, MD Bittinger Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CIRRHOSIS LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ROBABLE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has be irector, page 2 sl autopsy performed 1 ☐Yes 2 ☐ No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral C completely filled i

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

1 Seden

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number NOVEMBER 18 D 26907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD

State Registrar

				Pleas	e Type or Pr State of M										0000
		•	For State Registrar		State of iv	iai yiai i		tificate				Reg. No	4010	Ĵ	8060
	Physicia	ın/	1. Decedent's Nam	e (First, Middle, L	.ast)	_					2. Date of De Month	Da	F1		Time of Death
~	Medic Examin	cal			ETH_NOCK ive street and number)			4b. City, To	own, or Loca	tion of Death			c. County of Dea		2005 M
" Same	Lami		Poninsi	•	Giorni Mad		conter	<	Solic	Sbur	Y		Vican		
	Funeral Director		5. Social Security N 228-24-1		1 □ M 2 □ F	ge (In <i>yr</i> s. Ia	ast birthday) Yrs.	If Under 1 Months	Year If U Days Ho	Inder 24 Hrs. urs Min.	8. Date of Bir (Month, Da 01/23/	th y, Year) 1910	9. Bi	rthplace (ountry) JA	State or Foreign
		_	Usual Residence of 10a. State				y, Town or Lo	cation						10d. In	side City Limits
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	h the h	Funeral Director	10e. Street and Nur		100	1 01110	<u> </u>	10f. Zip C	Code			10g. Ci	itizen of What C	ountry?	
	ath wit	uner	602 SEN	IIOR WAY	GATEWAY V		3. 13. V	Vas Deceder	nt of Hispani	c Origin? (Spe	ecify Yes or No-		JSA 14. Race - Am	erican Inc	dian,
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at , the Medical Examiner must be notified at		1 Never Man	ied 2 Marrie	Armed Forces?)	1	Yes, specify Yes 2	y Cuban, Me	xican, Puerto	Rican, etc.)		Black, Whi	te, etc.	,
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121	ad with Hygien Ither th	Be C	8 17. Father's Name (First Middle Las	<i>t</i>)		CARE	GIVER	18.7	Mother's Nam	e (First, Middle,	-	MEDICAL Surname)		
land	uld be filed within 7 1 Mental Hygiene. marked other than natic event, the M	To	CUSTIS		•		_			AGGIE					
Maryland 21215-0036	sho is i		19a. Informant's N										r Town, State, Z		
	and 2 s Health tem 27		ALICE AI 20a. Method of Dis		- NIECE	20b. P	lace of Dispo	sition (Name	of	7	iansbur Date	,	7A 2318 ocation - City o		State
mo	Page 1 nent of ant: If it			Cremation 3 5 COther (Spe	Removal from State	_	emetery, cren cton Co	-		11/1	4/10	Me1	fa. VA		
Baltimore,	permit. Page 1 and 2 of Department of Health Important: If item 27 any injury or other troones.	9	21. Signature of Fu	neral Septce/Lic	see /			. Name and				_			
			23a. Part 1. Enter	he disease, or co	nplications that cause	d the deat					Funeral or respiratory ar		, Accor	App	VA roximate val Between
	Physician/		Immediate Cause disease or condition	Final	y one cause on each lin	i.L	hoe	h							et and Death
-	Medical Examiner		resulting in death)	1	Due to (or as	a consequ									
		iner	Sequentially list co if any, leading to in cause. Enter Unde	nditions, nmediate	b. Due to (or as	a consequ	, , , , ,	ra		_		-			
	ath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	iinjury s	c. Due to (or as	a consequ	ence of):								
0	be exersician suburial	a	resulting in deathy	Cast.	d		,								
68760	tificate ing phy e as the	Med	IF FEMALE:											<u> </u>	
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent in the past 12. 1 ☐ Yes 2	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 G Feta at time of c	ıl death 3 ∟	Ectopic pre					23d. Date of de Month	elivery Day	Year
D. B	the deby the tached	Physi	g 🗌 Unknown		g 🗆 Unknown		ulate - to at		usa shan in	Dovt I	and Distri			- 41	
s, P.O.	res thai signed I be de		Part II. Other signi	icant conditions	s contributing to death	but not res	ulting in the t	ndenying ca	use giveri iri	raiti.	23e. Did t		use contribute t		4 Unknown
ord	v requi	plete									24a. Was auto		24b. Were a	utopsy fir	ndings available
Rec	The lav	Completed by									perfo 1 Yes	ormed?	death?		
Division of Vital Records,	sician: certifici	To Be	25. Was case referr examiner? 1 Yes 2	ed to medical No	Hospital:	tient 2 🗆	ER/Outpatier	at 3 🗆 DO4		f Death (Chec		dence l	6 ☐ Other (Spe	cify)	
of/	ng Phy Iter this Ineral d		27. Manner of Deat	-	28a. Date of inj (Month, Da	ury	28b. Time of injury		c. Injury at work?		28d. Describe			ony,	
sion	ttendi death. ctor: A y the fu	Certificate:	2 Accident 3 Suicide	Investigate 6 ☐ Could no	t be 28e Place of In	jury - At ho	me, farm, str	M eet, factory,	1 Yes	2 ∐ No	28f. Location (Street ar	nd Number or Ri	ıral Rout	e Number,
Divi	tal or Ars after al Director billing		4 ∐ Homicide	determin	ed building, e	tc. (Specify	7)				City or Tov	vn, State	e)		
	Hospi 24 hou Funer eted fill	Medical	(Check S	Medical Exa	hysi⊏ian: To the best o aminer: On the basis of lurse Practioner: To the	examination	and/or inves	tigation, in m	v opinion, de	ath occurred a	t the time, date a	and place	e, and due to the	cause(s)	and manner stated.
	To the within To the compl	Σ	only one) 3 29b. Signature and		dise Fractioner. 10 (III	Desiron	y Kilowleage, i	29c.	License num	ber		29d. Da	ate signed (Mon		(ear)
	12		*				00.1 =		100-1	741	0	11/1	1/10		
	Sy		30. Name and add	ENA DO	no completed cause of 0.008 :	death (Item	23a) (Type, F ROLL	rint) St.	SALIS	buru	mel	_ ;	21801		
	Sta		31. Date filed (Mon			rar's Signa	ture Loa			1	1				
	Registr	al		-a,			//								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 5:00 A M ISOBEL FRANCES FOX NIMMO 6, 2010 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Hart Heritage Estates Forest Hill 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) **Funeral** Days Month, Day, 1 🗆 M 2 🔀 F Virginia Director 212-38-2521 85 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Harford MD Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1 Vaughn Avenue 21014 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Public Elementary/Seconday (0-12) Education School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred McClanahan Ernest Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Ellwood/Daughter Vaughn Avenue, Bel Air, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 11/18/2010 Street, MD Holy Cross Cem. . Signature of Tuneral Service Lic 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Stage Rementia Onset and Death Physician/ yen. disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Certificate: To Be Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s

Medical

29a. Certifier

29b. Signature and title of certifier

ALGRAD

Cause (Uisease of Injury that initiated events resulting in death) Last	cDue to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23 d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Chec	ck only one) Asi-sten
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify) CDC
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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NOVENCE- 17, 20/0

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

State Registrar 665 W MAZ

MU

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPANELS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Marlene Elizabeth Owens October 8:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chester River

Social Security Number Kent Manor Chestertown 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Delaware If Under 1 Year **Funeral** (Month, Day, Year) 0/21/1934 1 □ M 2 🗓 F Director 221-20-4443 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I USA 205 David Drive 21620 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. é 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Loan Review Specialist Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Boyce Kathalene Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emerson Roy Owens - Husband 205 David Drive Chestertown, Maryland 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Odd Fellows Cemetery 11/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Delaware Signatu of Funeral Service Lic 22. Name and Address of Facility Fellows, Helfenbein & Newna, Funeral 130 Speer Road Chestertown, Maryland Home, 21620 23a. Part 1. Erret the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of Keart failure. List only one con each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ Sease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one, examiner? 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this Certificate: Manner of Death 28a. Date of injury (Month, Day, 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Yes 2 No Investigation Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date sig ded (Month, Day, Year)

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State Registrar 10. Name and address

31. Date filed (Month,

ohn David O'Brien	1- For State Certificate		/giene Reg. No. 2010	38063
Physician/ Jedical Examine	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year November 23, 2010	3. Time of Death 0709 hrs
	4a. Facility Name (if not institution, give street and number) 1011 Victoria Drive	4b. City, Town, or Location of Death Waldorf	4c. County of Death	<u> </u>
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		thplace (State or Foreign untry) nington,DC
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d, Inside City Limits
≹	Maryland Charles Waldorf			1 Yes 2 X No
t the Maryland Sa or 28a-f sh Diffed at once		10f. Zip Code 20602	10g. Citizen of What Cou United Stat	
fter death with "", or items 23 ier must be no	3 Midowed 4 Divorced III Yes Give Year 1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:		can Indian, Black, te
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once To Be Completed by Funeral Director	15 Decedent's Education (Considerable highest grade completed) 160 Decedent	dent's Usual Occupation (Give kind of w g most of working life. DO NOT use retir ity Assurance Insp	ed)	,
215-0036 be filed within 7 natal Hygiene, rked other than ent, the Medica		18.Mother's Name	(First, Middle, Maiden Surname)	
2121 2121 build be fi I Mental I marked ic event,	David P. O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		ne Lucey Jural Route Number, City or Town, State	, Zip Code)
, MD and 2 sho ealth and em 27 is raumati	0	L East Tonto St.,	Phoenix, AZ 85044 Date 20c. Location - City or	Town, State
Baltimore, pemit. Pages 1 at Department of He Important. If ite injury or other tr	1 Burial 2 X Cremation 3 Removal from State Brinsfie	Id-Echols Crem11/2	9/2010 Charlotte	Hall, MD
Balt permit Depart Impor injury	Harry 9 chobatt MOO81/ 30	0195 Three Notch R	sfield-Echols F.H. d., Charlotte Hall	
Physician Wedical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a. Upper Gastrointestinal Hemorrha		respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
≟xaminer	or condition resulting in death) Due to (or as a consequence of):			
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate Course Enter Underlying Course Course Course (Course Course)			
cuted Ind Transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			-
00, te be execut ysician and burial - tra	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transial Certification: To Be Completed by Physician/Medical Examples.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnar Other (Specify)	23d. Date of delivery Month	Year Year
, P.O. E res that the c signed by the be detached d by Ph		e underlying cause given in Part I.	23e. Did tobacco use contribute to	
of Vital Records, ig Physician: The law requires the this certificate has been signeral director, page 2 should be not To Be Completed				topsy findings available ompletion of cause of
tal Recision: The certificate eector, page	25. Was case referred to medical examiner?	26.Place of Death (Check of Death)	only one)	leveled .
of Vi ing Physi After this uneral dir in: To	1 V Yes 2 No I mpatient 2 Erroutpatie	of Injury 28c. Injury at Work?	Residence 6 Other 28d. Describe how injury occurred	Scene
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	Natural 5 Pending Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, st	1 Yes 2 No	28f. Location (Street and Number or Ru	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			or Town, State)	
To the Hos within 24 h To the Fun completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigned and manner stated.			
D I S I S	29b Signature and title of certifier (24 of Hallai	29c. License number O.C.M.E.	29d. Date signed <i>(Mor</i> November 24, 20	
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penr	n Street, Baltimore, MD 21201		
State Registra		KeS		

DHMH 17 Rev 1/2001 OCME 2006

			State of Maryland, State of Maryland, 19b, 11-19-2010,	/ Depa Per Cer	rtment of FHDR, HC tificate of L	lealth and N HD, a ll ea <i>th</i>	/lental Hygi Re	ene	10 3	8064	
	DI.		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year 3	. Time of Death	
	Physicia Medic		Joseph Francis O'Brien				November	ŗ 11,		:11 P M	
	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. Count	ty of Death		
	Farment		3684 Woodbine Road 5. Social Security Number 6. Sex 7. Age (In yrs. last to	hirthday)	Woodbir If Under 1 Year	NE If Under 24 Hrs.	8. Date of Birth	<u>н</u>	Oward 9. Birthplace	(State or Foreign	
	Funeral Director		138-26-4353 11 M 2 □ F 87	Yrs.	Months Days	Hours Min.	(Month, Day,) Sept 1.	^(ear) 1923	New J		
	, MC		Usual Residence of Decedent						101	I1-I O'I1 I1	
	Maryland 28a-f show otified at	Director	10a. State 10b. County 10c. City, To							Inside City Limits 1 Yes 2 No	
	or 28a	Dire	Maryland Howard 10e. Street and Number	WOO	dbine 10f. Zip Code		10	a. Citizen of	What Country?		
	with th	eral	3684 Woodbine Road		1	21794 21	L797		d State		
' 2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ No			ispanic Origin? (Spe n, Mexican, Puerto			ace - American I ack, White, etc.	ndian,	
21215-0036	ırs afte ural", I Exan	ed b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1941—71		☐ Yes 2 🛣 No	Specify:		Specif	Specify: White		
5-0	"2 hou "natu edica	Completed	15. Decedent's Education 1 (Specify only highest grade completed)	(Give k		ation during most of work	ing 1	6b. Kind of I	Business Indust	ry	
72	ithin ithin riene.	Con	Elementary/Seconday (0-12) College (1-4 or 5+) 5+		NOT use retired) mist/Hydi	rologist		Envir	omental	Agency	
<u>5</u>	Hygi othe		17. Father's Name (First, Middle, Last)	Cric	<u>150/11</u> y		e (First, Middle, Ma			.1901.07	
Maryland	d be f Menta arked	욘	Joseph Francis O'Brien			Lorett	a Marie	e He	rmann		
lan.	shoul and l		· · · · · · · · · · · · · · · · · · ·			and Number or Rura		-			
e,	and 2 Health em 27 ther t				Woodbine sition (Name of		odbine, M		nd 2179 1 - City or Town,		
nor	age 1 int of 1 tr If its		1 🗆 Burial 2🔀 Cremation 3 🗆 Removal from State ceme	etery, crem	natory or other place	:e)					
Baltimore,	mit. P. sartme sortan r injur.	9	4 Donation 5 Other (Specify) Final 21. Signature of Funeral Service Licensee			atory 11/ E Cremati			ine, Ma		
<u>~</u>	permi Depar Impo any ir		Quanto R Homas M0095	57 B	<u>everly L.</u>	<u>. Heckrot</u>	te, P.A.	Clark	sville,	MD 21029	
			23a. Part . Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dyin	g, such as cardiac	or respiratory arres	t,	Inte	proximate erval Between eet and Deeth	
	Physician/ Medical	7	Immediate Cause (Final disease or condition resulting in death)	1	ung c	cho ce			- 6	set and Death	
	Examiner		Due to (or as a consequent	ce of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):							
	cuted nd transit	Examiner	Cause (Disease or linjury that initiated events c.	as a consequence of):							
_	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence	ce oi).							
760	physics the	edic	d								
89	certifi inding use a	M/m	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal de		Ectopic pregnanc	21/		23d. D	ate of delivery		
Box 687	death the atte	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of deat 9 Unknown 9 Unknown		Other (specify)			N	Nonth Day	/ Year	
P.O.	ed by detacl	y Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use cor	ntribute to the ca	ause of death?	
l, S	luires t an sign uld be	ed b					1 X Yes	s 2 🗆 No	3 Probabl	y 4 🗆 Unknown	
Cor	aw rec as bee	nplet					24a. Was an autopsy	/	prior to comple	findings available etion of cause of	
Re	The l	Con					perform 1 Yes 2		death? 1 Yes 2	No	
ital	si cian certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EB		Oth	ace of Death (Chec er:		ه اتام			
o t <	g Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28	b. Time of	28c. Injun	y at	ome 5 Resider 28d. Describe hov				
on (anding sath. rr: Afte	ficat	1 🗖 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation	injury	M 1 □	Yes 2 No					
Division of Vital Records,	or Atter after de Director in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Street, City or Town,		ber or Rural Rou	ıte Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination are	nd/or invest	igation, in my opinio	on, death occurred a	t the time, date and	place, and d	lue to the cause(s) and manner stated.	
	o the vithin 2 o the londing	Me	only one) 3 Certifying Nurse Practioner: To the best of my kn 29b. Signature and title of certifier	nowledge, o	death occurred at the 29c. License				manner as stated ed (Month, Day,		
	->=0				D	48/84	4	11/1.	2/10		
	104		30. Name and address of person who completed cause of death (Item 23 Elhamy ESKander, MD 50		rint) 7th 5	treet F	-rederic	K,r	1D 2	170/	
	Sta Registr		31. Date filed (Month, Day, Year) 6 2010 32. Registrar's Signature		arked						
	3.0										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 7:00 P_M 2 Date of Death Physician/ Ohler Sharon Ann November 15 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 19 W. 1st ST Allegany Cumberland Social Security Number 6. Sex Age (In yrs. last birthday)
59 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 11 1951 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F Hours West Virginia 220-58-0199 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Allegany Cumberland 1X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 W. 1st ST 21502 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. <u>Ş</u> Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Campbell Stanley Ida Hott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6933 Linn Drive, Roanoke, Virginia 24019 19a. Informant's Name/Relationship (Type, Print) Jayson Ohler/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 11/20/2010 Westernport Maryland Philos Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home F. W 111 Church St. Westernport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 ed by the attending properties of detached for use as as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 ☐ Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Morbid obesity 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1X Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Exhedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tiple of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D09157 11/16/10

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 17

Dr. Paul Snow, 124 W 3rd St, Cumberland, Maryland

32 Registrar's Signature

onald Alan Perk	1	State of Maryland / Department of Health and Menta - For State Certificate of Death	al Hyg		2 U eg. No.	0 08066	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Deat Month	Day Year		
<u>ledical Examir</u>	er	Ronald Alan Perkins	1	November	7, 2010	1756 MIS	
7		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Cheverly, MD Cheverly, MD			4c. County o		
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24Hrs.	B. Date of Birt		Birthplace (State or Foreign	
Funeral Director		Months Days Hours	Min.	3/31/		Country) DC	
	ŀ	577-78-7095 1 X M 2 F 54 Yrs. Usual Residence of Decedent		3/31/	1930	DC	
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
nd show	اڃ	DC Washington				1 X Yes 2 No	
Maryland 28a-f show any d at once.	Director	10e. Street and Number 10f. Zip Code		10	0g. Citizen of Wh	at Country?	
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once		417 55th St. NE 20019			U.S.A.		
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Interval			- 14. Race White	- American Indian, Black, , etc.	
r deat or ite	퇿	1 Yes 2 X No			Specify:	Black	
rs afte		3 \overline{\text{Widowed}} 4 \overline{\text{Divorced}} \overline{\text{If Yes, Give Year} \ \text{or Dates:}} \overline{\text{1} \overline{\text{Yes}} 2 \overline{\text{X}} \overline{\text{No. specify.}} \ \text{or Dates:}} \\ \text{15. Decedent's Education (Specify only highest grade completed)} \overline{\text{16a. Decedent's Usual Occupation (Give k)}} \\ \text{16a. Decedent's Usual Occupation (Give k)} \\ 16a. Decedent	ind of wor	k done	16b. Kind of Bus	siness/Industry	
2 hour	ğ	Elementary/Secondary (0-12) College (1-4 or 5+)	use retired	i)			
036 thin 7 re.	Completed by	12th Maintenance Wo			Priv		
21215-0036 Juld be filed within 72 hours after of Mental Hygiene. marked other than "matural", or ceent, the Medical Examiner m	ैं	17. Faule S Name (1 11st, Michael, East)	•	irst, Middle, M 1y Per	Maiden Surname)		
2121 uld be fil Mental F marked	Be	W11116 111				n State Zin Code)	
D 2 should and M 7 is m		19a. Informant's Name/Relationship (Type, Print) Nekita Robinson-Daughter 19b. Mailing Address (Street and Numl 417 55th St. NE	Wa	ashin	gton, D	C 20019	
ages I and 2 shount of Health and Int. If item 27 is rother traumatic	L	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		Date	20c. Location -	City or Town, State	
imore Pages 1 nent of H ant: If i	1	1 Burial 2 Cremation 3 Removal from State crematory or other place) Riverdale Park Cre	1/1	6/10	Riverd	dale, MD	
Baltimore, permit. Pages 1 at Department of Her Important: If ite	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility					
Depart Depart		2019 MLK Jr A	ve S	SE, Wa	ásh. DC	20020	
Physician		26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	ardiac or re	espiratory arr	est, shock, or hea	Detween Onser and	
xaminer	١	Immediate Cause (Final disease a. Chronic Alcoholism				Death	
Administ	-	or condition resulting in death) Due to (or as a consequence of):					
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	Examiner	cause, Enter Underlying Cause	_		_		
ted Insit	EXa	events resulting in death) Last Due to (or as a consequence of):					
oe executed totan and urial - transit	dical	UNPENDED AMENDED#4b,perME,G910,12/27/2010,W	 S				
60, ate be hysici e buri	Sed a	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	delivery	
x 68760, h certificate b tending physic	an/	past 12 months?	pregnanc	у	Month	Day Year	
Box 68760 e death certificate to the attending physical ed for use as the bu	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown					
that the denetated by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I.			bute to the cause of death?	
F. P.C.	d b			1 Yes	s 2 No 3	Probably 4 Unknown	
cords aw requirements been a should	ete			24a. Was autor		Were autopsy findings available prior to completion of cause of	
eco ne law te has	Completed					death? ✓ Yes 2 No	
tal Rection: The certificate ector, page	ပိ	25. Was case referred to medical 26.Place of Death	(Check on	ly one)			
Vita ysicis direc	To Be	1 Yes 2 No		Home 5	Residence 6		
of ing Pt After uneral		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work 1 ✓ Natural 5 Papeling		8d. Describe	how injury occurr	red	
ion ttendi death. ttor: y the f	atio	2 Accident Investigation		Of Landing (Cine at and Niverb	er or Rural Route Number, City	
Division of Vital Records, P.O tal or attending Physician: The law requires that I rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detax	Certification:	3 Suicide 6 Could not be determined (Specify)	c. 2	or Town,		er of Marai Mode Maribor, only	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and pla	ace, and d	ue to the cau	se(s) and manner	r as stated.	
the H hin 24 the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	curred at t	the time, date	and place, and o	due to the cause(s)	
To To con	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number			29d. Date sign	ed (Month, Day, Year)	
		Caliale MAN O.C.M.E.			November	8, 2010	
<u> </u>		30. Name and address of person who completed cause of death (item 23a)					
2 1		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 2120	1	<u>.</u>		
S Regis	ate						
X(3)0 S	40.14			_			

		-	For State Registrar	State of M	•	epartment of F Sertificate of D			giene Reg. No.	38067
	Dhysisis	/	1. Decedent's Name (First, Middle, La	ŕ	 			2. Date of Dea Month	th	3. Time of Death
	Physicia Medic			y D. Porte	er	T		Novemb		
	Examin	er	4a. Facility Name (if not institution, giv Hebrew Nurs				Location of Death	1	4c. County of Dea	ath gomery
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth		irthplace (State or Foreign ountry)
	Director		215-20-4087	™ 2 □ F	83 Yrs	s. Months Days	Hours Will.	Oct. 6	9. B Year) 927	DC
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryla 28a-f s stified	rect	Maryland Montgo	mery	i		Rockvil	.le		1 X Yes 2 □ No
	a or 2	al Di	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What C	
	th with ms 23 must	Funeral Director	6121 Montrose Ro	ad 12. Was Decedent B	Tues in II C	3. Was Decedent of H	20852	posify You or No-		States
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if then 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	à	11. Marital Status 1 ☐ Never Marrled 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		If Yes, specify Cuba	n, Mexican, Puerto	echy fes of No-	14. Race - Am Black, Wh Specify:	
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bu	filed val Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, I		
ylaı	ild be Menti narked	잍		rge Porte					McDuffie	
Mar	2 shouth and the and the and the and the traum		19a. Informant's Name/Relationship (lailing Address (Street a 26 Deal Dr				· ·
e,	1 and of Heal item (Blondine D. Porte		20b. Place of Di	sposition (Name of		Date	20c. Location - City of	
<u><u>E</u></u>	Page ment c ant: If ury or		1 ☐ Burial 2 X Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec			crematory or other place S Crematory	: NOV.	22,2010	Clinton	Maryland
Baltimore, Maryland	permit. Page 1 a Department of F Important: If ite any injury or ott		21. Anature of Funeral Service Lice	Dock	Mite	22. Name and Addres			uneral Hom hington, D	
			23a. Part Loter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each line	the death. Do not				est,	Approximate Interval Between
- 4	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Advan		ementia				Onset and Death
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3760	ificate ig phy as the	Medi	IF FEMALE:	- u						
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3	;y		23d. Date of o Month	lelivery Day Year
0	at the d by the letache	Phy	9 Unknown Part II. Other significant conditions		out not resulting in the	he underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
s, P	ires th signe Id be c	d by						1 🗆 🗅	Yes 2 💢 No 3 🗆	Probably 4 🗌 Unknown
ord	w requ	Completed						24a. Was a		autopsy findings available o completion of cause of
Rec	sician: The law r certificate has b lirector, page 2 s	Com						perfor	rmed? death?	es 2 No
ta	cian; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (Che			
Ž	Physi rthis o	일::	1 ☐ Yes 2 💢 No 27. Manner of Death	1 ☐ Inpati 28a. Date of inju		atient 3 LI DOA	4 Nursing F		lence 6 Other (Spe	ecify)
ouc.	nding ath. r: After re fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident _ Investigation	(Month, Da	y, Year) inju	ry work			,,	
Division	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Exar	niner: On the basis of e	xamination and/or in	ath occured at the time envestigation, in my opinion ge, death occurred at the	on, death occurred	at the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	Vithi To the		29b. Signature and title of certifier			29c. Licenso			29d. Date signed (Mor	
			ma farl				64871		11-8-2	010
R			30. Name and address of person who			ntrose R	_d	ocknill	MD	20852
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 6 2010		r's Signature	/	. 10			

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 27,2010 15:58 RAYMOND J. PUMPHREY Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Takoma Park 4c. County of Death
Montgomery Examiner Washington Adventist Hospital 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex **Funeral** OCT 2 Day 927 Days Hours 1 ★M 2 □ F 83 Washington, DC 229-26-9288 Director Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** Maryland Prince George's Berwyn Heights 1 X Yes 2 ☐ No 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20740 5717 Berwyn Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. Completed by 1X☐ Yes 2 ☐ No If Yes, Give Year or Dates.WWII 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Pendleton Edward N. Pumphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5717 Berwyn Road Berwyn Heights, Maryland 20740 Darlene Holtz -Caregiver 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1
Department of
Important: If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 12/1/2010 Crownsville, Maryland 21. Signatur Pheral Se vice License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATTHERO SCLEROTIC HEART DISEAST Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTOUSIEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No cate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown FAILURE DIMSTULIC 24b. Were autopsy findings available prior to completion of cause of death? HEMRIT 24a. Was an autopsy performed? 1 🗌 Yes 2 🗹 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) IDDELE NOVEMBER 29,2010 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLHAD TERRY JODELS, MD, FACOD PARK, 7600 CARROLL AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2010 Registrar DHMH 17 Rev 7/2009

ORIGINAL

2/

10-08835 Diane Palmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Serve	"har"		0	1	14	1	-	-

	1- For State Registrar		Certific	ate of Dea	ath			Reg. No.	10		
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								/ear	3. Time of Death	
Medical Examiner	Diane Elaine Palmer November 18, 2010									0545 hrs	
)	4a. Facility Name (if not institution, give street and number) Calvert Memorial 4b. City, Town, or Location of Death Prince Fredrick Ca										
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last bir			If Under 2		Birth(MM/DD/YY			
Director	577-86-3924	1 M 2 X F	46	Yrs. Mon	iths Days	Hours	May May	22, 196	4 Foreig	untry) DC	
źu	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
_ aw a		vert	•	peake B	oach					1 Yes 2 X No	
Maryland 28a-f show any d at once. ector	10e. Street and Number	VEIL	Onesa		ip Code			10g. Citizen of	What Coun		
the land	6130 8th Str	eet			0732			United			
death with r items 23 sust be no uneral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.				(Specify Yes or Jerto Rican, etc.)		ce - Americ	can Indian, Black,	
or deat	1 Never Married 2 X	1 Yes 2	X No						Wh	ite	
rs after unine	15.5	vorced If Yes, Give Year or Dates:	nleted\ 16a	Decedent's Usua	2 No s		t of work done	Specifi 16b. Kind of	y.		
O036 within 72 hour giene. her than "natu t. Medical Exan	Elementary/Secondary (0-12			during most of w				Tob. Kild of	Dusiness/ii	ildustry	
36 Frin 72 than edical	2 containing to the	2		an Proc	essor			Mortg	age B	lank	
5-00 ed wit tygien other the M	17. Father's Name (First, Middle		1 230	, dii 1100		Mother's N	lame (First, Midd	e, Maiden Surnar		- Carrie	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE COMPIE	Robert Albert	Lowe				Lilli	an Elai:	ne Holde	n		
21. Could the double of Merice of the country of Merice of Tolumber 1	19a. Informant's Name/Relation		19	b. Mailing Addre	ss (Street a	nd Number	r or Rural Route I	Number, City or To	own, State,	Zip Code)	
MD ad 2 sho alth and m 27 is aumatic	Daryl Palmer	/ Husband	1 6	130 8t	h Stre	et, C		ke Beach			
re, s 1 an f Hea ff iten	20a. Method of Disposition 1 Burial 2 X Crematic	n 3 Pemoval from Sta		of Disposition (Nation) of Disposition (National Internation of the place of the pl		tery,	Date	20c. Locatio	n - City or	Town, State	
Pages ent o	4 Donation 5 Other S			remator		1	1/24/2010	Clint	on, N	MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite Injury or other injury or other in	21. Signature of Funeral Service	Licensee								ert, P.A.	
	Gary J. Goff	<u>/</u>								Approximate Interval	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
\Examiner	Immediate Cause (Final diseas or condition resulting in death)			rdiovas	cular	Disea	ase			Death	
A.		Due to (or as a conse b.	quence of):								
Jer .	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):								
ted I unsit Examiner	(Disease or injury that initiated	c. Due to (or as a conse	aneuce of).								
760, ficate be executed g physician and the bunial - transit w/Medical Exi	events resulting in death) Last	d.									
760, ficate be executed by the burial - tr	X UNPENDED	AMENDED 23	Sa,27 pe	er me g9	10 12-	-27–10) vt				
760, ficate be g physici the buri	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcom							of delivery		
tox 68' eath certification is a second in the second in th	past 12 months?	past 12 months? 2 Fetal death 3 Ectopic pres							ancy Month Day		
). Box 68' the death certiff by the attending tched for use as Physician	1 Yes 2 No 9 🗸 Ur		Olifer (Option)/								
O. But the dath tached	Part II. Other significant condi	tions contributing to death	but not resultin	g in the underlyin	ng cause give	en in Part I.	23e. Di	d tobacco use cor	ntribute to t	he cause of death?	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. Sal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly entification: To Be Completed by Pertification: To Be				_	_		_ 1 🗆 '	Yes 2 No	3 🗸 Proba	ably 4 Unknown	
Records, The law requirer ficate has been sig., page 2 should be Completed							24a. W	as an 24b topsy		opsy findings available ompletion of cause of	
eco he law te has ge 2 s							ре	rformed? s 2 ✓ No	death?		
tal Rection: The Certificate ector, page	25. Was case referred to medical	al l			26.Place of	Death (Ch	eck only one)	3 2	1	2	
Vital hysician: this certi I director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	t 2 🗸 ER/O	utpatient 3	DOA Oth	ner ₄ Nu	ursing Home 5	Residence 6	Other:		
of Affer the function on: T	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 28b.	Time of Injury	28c. Injury a	t Work?	28d. Describ	e how injury occu	rred		
ion tendi eath. tor: ,		ding stigation	<i>′</i>		1 Yes	2 No					
ViS or At after d Direc in by	3 Suicide 6 Cou	ld not be 28e. Place of Inju	ry - At home, fa	arm, street, factor	ry, office build	ding, etc.		n (Street and Num n, State)	ber or Rur	al Route Number, City	
Division or spiral or Attending nours after death. Interal Director: After filled in by the fune. Certification:	4 Homicide	rmined (Specify)					01 10111				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ei	Tolloon only	hysician: To the best of my miner:On the basis of exam and manner stated.	-			-					
Me G T W T	29b. Signature and title of certifi			29	9c. License n	umber		29d. Date sig	ned (Mon	th, Day, Year)	
	//				O.C.M.I	F		Novembe	r 19. 20	10	
	Yourt Fr	ithall MA			O.C.IVI.I					10	
	30. Name and address of person	who completed cause of de	ath (Item 23a)		O.C.IVI.I						
	30. Name and address of person Pamela E. Southall, I		al Examine	r 111 Pen			e, MD 21201			10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	•	For State Registrar	State of	Maryland		rtment of F tificate of D		Mental Hy	Reg. No.	2010	38070
Physicia		1. Decedent's Name (First, Middle, La Daisy M.	est) Paln	ner				2. Date of De Month Novembe	Day	, 2010	3. Time of Death 10:45 AM
Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									1
Francis		Fox Chase Rehab. 5. Social Security Number 6.				Silver S	Spring If Under 24 Hrs	8. Date of Bir		ntgomer	hplace (State or Foreign
Funeral Director		579-82-0176	1 □ M 2 🛛 F	7. Age (In yrs. Ia: 97	Yrs.	Months Days	Hours Min	2-17-1	913		intry)
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City	, Town or Loc	ation					10d. Inside City Limits
Maryla 28a-f s atified	Director	Maryland Montgome	ery	Silv	ver Spi	ring					1 🏋 Yes 2 □ No
ith the 3a or t be no	ralD	10e. Street and Number 2015 East West H	Highway			10f. Zip Code 20910			-	zen of What Co ted Sta	
leath w	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S		/as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-	-	14. Race - Amer	ican Indian,
after o	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Date			Yes 2 No	Specify:	to riican, etc.,	s	Black, White Specify: B1a	
hours natura dical E	plete	15. Decedent's (Specify only highest o	Education	es. 		ent's Usual Occupa ind of work done d		orkina	16b. Kir	nd of Business I	ndustry
ithin 72 ene. • than ' he Me	Completed	Elementary/Seconday (0-12)	College (1-4	1 or 5+)	life. DC	NOT use retired) maker	aring most or we	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dome	estic	
filed wall Hygis I other vent, t	Be	17. Father's Name (First, Middle, Last)		HOME	liakei		ame (First, Middle,	<i>Maid</i> en S		
uld be I Ments narkec natic e	<u>و</u>	Josiah Palmer						ine McKa			
d 2 sho alth and 27 is r r traun		19a. Informant's Name/Relationship Matilda Watson-		aughter		g Address <i>(Str</i> eet a Varnum St		ura <i>l R</i> oute <i>Numbe</i> i shingt cr	er, City or T	Town, State, Zip 20011	(Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heathl and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from S	Name CE	metery, crem	sition (Name of atory or other plac	e)	Date		cation - City or	
nit. Pag artmen ortant: injury		4 Donation 5 Other (Special Signature of Function Service Mose	/-	For		oln Cemet		ort Line		ntwood, Funeral	
permit Depar Impor any ir		Aucha Throng				01 Blade					
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each	h line.			g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	_ a	nic Bra		arome					
Examiner	<u>_</u>	Sequentially list conditions,	b. ———	nary Ar		isease					
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or Attending Physician: The law requires that the death certificate be executed after death. Jinector: After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	•	d								
ath certifica attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar		. F			2	23d. Date of deli	ivery
death he atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown		ant at time of d		Ectopic pregnanc Other (specify)	у			Month	Day Year
that the de	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									the cause of death?
v requires the been signer should be a	ted b							1 🗆	Yes 2X	No 3□Pr	obably 4 🗆 Unknown
The law re cate has be page 2 sh	Completed							24a. Was auto		24b. Were aut prior to death?	opsy findings available completion of cause of
an: The tificate or, pag		25. Was case referred to medical	T			26. Pla	ace of Death (Ch	1 🗆 Yes	2 y No		2 🗆 No
hysicia his cert I direct	To Be	examiner? 1 Yes 2 No		npatient 2 🗆 I	ER/Outpatien	Othe		Home 5 Resi	dence 6	Other (Speci	fy)
ding Pr h. After th funeral	sate:	27. Manner of Death 1 Natural 5 Pending		f injury a, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe I	now injury	occurred	
• Attender death er death ector: /	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o			et, factory, office	100 2 110			Number or Rur	al Route Number,
oital or ours afte eral Dir illed in	Sal	building, etc. (Specify) City or Town, S									· · · · · · · · · · · · · · · · · · ·
To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical			s of examination	and/or investi	igation, in my opinio	n, death occurred	d at the time, date a	and place,	and due to the	ause(s) and manner stated
Vithi Volume	-	29b. Signature and title of certifier		\supset		29c. License				e signed (Month	-
C		30 Name and address of norses who	completed cause	of death (Item	93a) (Tuno D	R0960		, ,,,		/17/2010	
2		30. Name and address of person who Babette Pennay,				Tÿ Grove	Kd Roc	kville,	MD 2(UODU Su:	rce 130
Sta	te	31. Date filed (Month, Day, Year)	32. Reg	girtrar's Signati	ure						

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 '45am Patricia Louise Petty Vovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata enter recica 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number Birthplace
 Country) (State or Foreign **Funeral** Months Days Hours Washington, DC 1 □ M 2 🖾 F 68 Yrs 08/18/1942 220-38-2114 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 26835 Three Notch Road 20659 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify Completed by Specify: 3K Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Toll Sergeant Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Important: If item 27 is marked any injury or other traumatic evonce. Nettie Martin ပ Ernest C. Steele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Buckbee/Friend 309 Sunset Lane, Prince Frederick, MD 20678 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Brinsfield-Echols 11/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01403 Danielle Ward 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ich Expression Immediate Cause (Final disease or condition resulting in death) **Physician** BITTAKTIVE) week /Medical Due to (or as a consequence of): Examiner 12 m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending ph for use as th IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) P.O. I ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an funeral director, page 2 autopsy certificate 2 X No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number price BULL 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or							egible.		
		State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death								Reg. No. 2010 38072			
Physicia Medic		1. Decedent's Name Louis			abeth	Ро	pe	2. Date of Death Month Day Year			Year	3. Time of Death 0:430 M	
Examin				give street and num	Center		Location of Death		4c. Cou	nty of Death	gany		
Funeral Director		5. Social Security No. 215-42-47	. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 03/07/	th ay, Year)	9. Birth Cou	place (State or Foreign htry). Virginia				
	or	Usual Residence of 10a. State			10c. C	City, Town or Lo	cation		100/01/			10d. Inside City Limits	
e Maryla r 28a-f s notified	Direct	MD 10e. Street and Nun		legany	Ш	Cu	mberland				1 X Yes 2 No		
with th	Funeral Director			ence Stre	et		10f. Zip Code	21502			Citizen of What Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed		12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 💢 No e	 1U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: 					14. Race - American Indian, Black, White, etc. Specify: Black		
72 hours "natur edical B	Completed		15. Decede	nt's Education est grade completed)		(Give	lent's Usual Occup kind of work done o		king	16b. Kind of			
within 7 giene. ner than t, the M		Elementary/Seconday (0-12) College (1-4 or 5+) Cook Cook							Pre	e-Scho	ol		
d be filed Mental Hy arked ott	To Be	17. Father's Name (f Warner	First, Middle, L	,	Vashing	gton		18. Mother's Nan Eliza			_{me)} Beckwi	th	
nd 2 shoul ealth and I m 27 is ma		19a. Informant's Na Terrance	L. Po								ty or Town, State, Zip Code) rland, MD 21502		
Page 1 al nent of H int: If itel		20a. Method of Disp 1 🌠 Burial 2 I 4 🗌 Donation	☐ Cremation	3 Removal from	Ctata	Place of Dispo cemetery, cren illcres	sition (Name of natory or other plac t Mem。 Pa	e) ark 11/2	Date 2/2010	20c. Locatio	n-City or T erland		
permit. Departn Importa any inju		21. Signature of Fur	neral Service I	Jan M	7		Name and Addres					Home, P.A. 21502	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death Onset and Death Outpear's Due to (or as a consequence of):										Interval Between Onset and Death	
executed ian and irial-transit	ıl Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
icate be physic s the bu	ledica			d									
To the Hospital or Attending Physician: The law requires that the death certificate be within 4 burns after death certificate be within 4 burns after death. The the Euneria Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burns letter filled in by the funeral director, page 2 should be detached for use as the burns letter filled in by the funeral director, page 2 should be detached for use as the burns letter filled in by the funeral director, page 2 should be detached for use as the burns letter filled in by the funeral director.	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 ☐ Fe nantattime o	etal death 3 🗌	Ectopic pregnand Other (specify)	у			Date of deliv	rery Day Year	
uires that ti n signed by ild be deta	þ	23e. Did tobacco use contributing to death out not resulting in the dilderlying cause given in Part i.											
The law req ate has bee page 2 shor	Completed								24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy ormed?		psy findings available ompletion of cause of	
sician: certific lirector,	To Be	25. Was case referre examiner? 1 Yes 2	-	Hospital:	Innationt 2	☐ ER/Outpatier	Othe	ace of Death (Chec	sk only one) ome 5 □ Resi	dana 0 🗆 0	H/C		
nding Phy th. : After this s funeral c		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	h 5 🗌 Pendir Investi	28a. Date of (Mont		28b. Time of injury	28c, Injury work	/ at	28d. Describe				
al or Atter s after des il Director ed in by the	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Place	of Injury - At I		eet, factory, office		28f. Location (S City or Tov		nber or Rura	I Route Number,	
he Hospit in 24 hour ne Funers pleted fills	Medical	(Check 2	Medical E	Physician: To the bi ixaminer: On the bas Nurse Practioner:	is of examinati	ion and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and	due to the ca	use(s) and manner stated.	
	_	29b. Signature and	11:1				29c. License	1711		29d. Date sign			
2			ess of person	who completed caus	e of death (Ite	em 23a) (Type, F		erland M	ID 2150		CT 128	-18,2010	
TIRS Stat		V 1 K 31. Date filed (///ion)/				nature save	•	or rand, I		-		· · · · · · · · · · · · · · · · · · ·	
Registra	ar	11.07	22 - LO	Lance	- ps.	July of Care	F1 (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ \mathbf{P}^M .45 Velma I. Proffit

4a. Facility Name (if not institution, give street and number) 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Eagle Nursing
5. Social Security Number 6. Sex Alleg Rehab Center Lonaconing 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) Months Days Hours Min. Country) 82 Director 309-28-4903 8 1927 In. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Westernport MD 1 X Yes 2 No Alleg 22709 Horse Rock RD. 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 22709 Horse Rock Rd. S.W. 21562 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mineral <u>Dental Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Duward Phillips Martha Bishop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21562 19a. Informant's Name/Relationship (Type, Print) 22709 Horse Rock Rd Westernport, MD Frederick Proffitt ₩ Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗖 Removal from State 11-16-10 | Cresaptown, MD 4 Donation 5 Other (Specify) carpell Funeral 21. Signature of Funeral Service License 22. Name and Address of Facility Fredlock Funeral Home ST Piedmont, Jones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RENAL Physician/ disease or condition resulting in death) Medical Examiner HYPERTENSIUM Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie Hardhu 02690 NOVEMBER 16 2010

Registrar
DHMH 17 Rev 7/2009

State

COMBERGAND, MD. 2150.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2010 Year Hazel Marion Parks Nov. 12 11:10 pM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. June 8, 1921 1 M 2 X I 89 Director 579-36-9371 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10a. State 10c. City, Town or Location 1 Tes 2 No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 Leisure World Blvd., #218 3100 N. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates Specify Black 3 √Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Federal Government Operator 12 should be filed we and Mental Hyg event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Ellen Jane Christian David Taylor 19a. Informant's Name/Relationship (Type, Print) 196 Mailing Address Street and Number or Rural Route Number City or Town, State Zip Code)
3100 N. Leisure World Blvd., #218
Silver Spring, MD 20906 Maggie Booker/Daughter Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lincoln Memorial
Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State $^{N}2810^{17}$ Suitland, 4 ☐ Donation 5 ☐ Other (Specify) Francisco Facility I ins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral S Inc. Spring, MD 23a. Part — Inter the disease, or complications that caused the death. Do not enter the mode of tying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Securation list concludes if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of signed by the attending physician and abe detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months 1 Yes 2 No Day Yea 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ne 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate has page 2 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 - No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at work? injury 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Prwithin 24 hours after death.
To the Funeral Director; After the completed filled in by the funeral

Maryland 21215-0036

Baltimore,

3

State

Registrar

Medical

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check only offe)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Charles Karesh,

NOV

Investigation 6 Could not be

determined

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

MD

32. Registrar's Signature,

1- 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

26033 Ridge Road, Damascus,

anke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State

MD 20872

10-08618 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffery Samuel Pickard State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 0141 hrs November 10, 2010 Jeffrey Samuel Pickard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 674 Ocean Parkway Ocean Pines Worcester **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign CountryMichigan Days Months Hours Director 369-74-8014 1 X M 2 F 51 31, 1959 Jan. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 X No permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. MD Worcester Berlin irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 B East Mallard Drive 21811 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 X Married 1X Yes 4 Divorced If Yes, Give Year 1977-1997 3 Widowed 1 Yes 2 X No specify: white Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " Petty Officer U.S. Navy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester L. Pickard Ethel Ann Packingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic Q Edith Vogl Pickard 21 B East Mallard Drive Berlin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State tant: Crematory of Delmarva |11-12-2010 | Delmar, Delaware Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar, 13 East Grove Street 19940 a. Part I. Inter the discress of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? certificate Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 V Yes No 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Nov 10. 2010 Operator of motorcycle that veered off road and 1 Natural 0140 hrs 1 Yes 2 ✓ No Pending the struck fixed objects 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 674 Ocean Parkway, Ocean Pines , MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Fo the Hospital or Attending Physician: within 24 h To the Fur completely

Pamela E. Southall, MD 31. Date filed (Month, Day, State 2010

29b. Signature and title of certifie

Assistant Medical Examiner 32. Registrar's Signature, Breun

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Registrar

29d. Date signed (Month, Day, Year)

November 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 10:15 Am 2010 Tamara Quattrociocchi Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #601 6111 Montrose Road Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1070971960 50 Washington, DC Director 577-88-2736 be filed within 72 nowfential Hygiene.

arked other than "natural", or items 23a or 28a-f snowtic event, the Medical Examiner must be notified at Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6111 Montrose Road #601 20852 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. è 1XXNever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Clerical 12 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Morris Louis G. Margaret permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Quattrociocchi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6613 E. Wakefield Dr. B-1 Alexandria, VA 22307 Sistler Quattrociocchi <u>Christina</u> altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 11/21/2010 1 Burial 2 X Cremation 3 Removal from State Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licens ^{22. Name and Address of Facilit}George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon HIll, Maryland 20745 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA ∲nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, Il any leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) DIABETES MELLITUS , TYPE I 40 + yrs. physician and the burial-transit Exar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 X No signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perfori death? Physician; The certificate l 1 ☐ Yes 2XX No 1 Yes 2 No Hospital or Attending Physiciam: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 KResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: Tuths best of my knowledge, de 29b. Signature d title of certifie 29d. Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 8218 Wisconsin Avenue #305 Bethesda, MD MD Susan J. Miller

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	State Registrar			Cer	tificate of l	Death		Reg. No.	ZUIU	38011
	Diversity in		1. Decedent's Name (First, Midd	fle, Last)					2. Date of I	Death	/ Year	3. Time of Death
	Physicia /Medic		Rudolph Charles	s Rochester					Octob			2:00 A M
	Examin		4a. Facility Name (If not institution	on, give street and number)			4b. City, Town, or	Location of Death			County of Dea	
***	0		1102 Goldsboro		a /l- um last him	thday	Barclay If Under 1 Year	If Under 24 Hrs.	O Data of I		een Ann	thplace (State or Foreign
	Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☐ MM 2 ☐ F	ge (In yrs. last birt 78	Yrs.	Months Days	Hours Min.		Day, Year)	C	ountry)
	Director		220-26-2248 Usual Residence of Decedent		70				05/12	/1932	Mar	yland
	ylanc Jow		10a. State 10b. County	у	10c. City, Town	n or Loc	ation					10d. Inside City Limits
	a-f sl	양	MD Queen	Anne's	Barcla	У						1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	ountry?
	ath w 23a		1102 Goldsboro				21607			USA		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or I Rican, etc.)	No-	 Race - Ame Black, Whit 	
36	rs aft	by F	1 ☐ Never Married 2 ☐XMar 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	NO	1	□Yes 2X No	Specify:			Specify: p.1	.ack
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. Independent than "natural", or items 23a or 28a-f show event, the Medical Everniner must be notified at	ted	15. Decede	nt's Education	16a.	Deced	ent's Usual Occup	ation		16b. K	ind of Business	
215	hin 7: an "n	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5	5+)	(Give k life. D	and of work done a ONOT use retired	during most of world)	ing			
	ygien /gien er th	Son	12	2		reho	ouse Fore				. DuPor	nt
nd	~ = 0 2	Be (17. Father's Name (First, Middle					18. Mother's Nam	e (First, Midd	le, Maiden	Surname)	
yla	Men Men arke	၉	Arthur Roland l	Rochester				Mildred				
Maryland	i 2 should be filed w th and Mental Hygie 7 is marked other t traumatic event, th		19a. Informant's Name/Relation	, , , , ,		,		and Number or Ru		-		
	l and Healt		Jacquie Rochest	ter - Wife				Road Ba	rclay, Date		Land 21 ocation - City or	
altimore,	Pages nent of I ant: If ite ury or o		1 XBurial 2 ☐ Cremation		1		sition (Name of natory or other place	i			•	,
를	permit. Pages Department of Important: If if any injury or once.		4 ☐ Donation 5 ☐ Other (a		Roches	22.	Cemetery Name and Addre	ss of Facility	3-1-27		1292011072	Maryland Maryland
Ba	Depi Impo any		Kut of	Delpenber	2	Fe.	llows, He	elfenbein Road Ches	& New	nam F	uneral	Home 21620
			23a. Part 1. Enter the disease,	r complications that caused	d the death. Do r						тугана	Approximate Interval Between
24	Physician		Immediate Cause (Final	st only one cause on each li	ine. Gran	->-1	F-18					Onset and Death
1	/Medical		disease or condition resulting in death)	d	a consequence							a monito
	Examiner			h								
	₽ .≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as	a consequence	of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		- 6		<u></u>				
60,	cian a		resulting in death, East	Due to (or as	a consequence	oi):						
68760,	death certificate be executed e attending physician and id for use as the burial-transit	Medical		d								
×	eath certific attending p for use as i	_	IF FEMALE:	23c. If yes, outcome	e of pregnancy						23d. Date of de	alivery
Bô	death e atter	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death at time of death		Ectopic pregnanc Other (specify)	У		.	Month	Day Year
P.0.	it the de by the tached	hysi	9 Unknown	9 ☐ Unknown								
	The law requires that the ate has been signed by thoage 2 should be detache	by P	Part II. Other significant condit	tions contributing to death b	out not resulting ir	n the un	derlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute t	to the cause of death?
ğ	v require been siç should b	edit							1]	Yes 2	□ No 3□ F	Probably 4 Unknown
ecc	e law re has be ie 2 sho	Completed							24a. W	as an topsy	24b. Were a	utopsy findings available completion of cause of
<u> </u>	: The	Son							pe 1 □ Ye:	rformed?	death?	s 2 No
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				l ou	26. Place of Dea	th (Check on	y one)		
of	Physi this o	၉	1 Yes 2 No	Hospital:		tpatient		4 LI Nursing H			6 ☐ Other (Spi	ecify)
Division of Vital Records,	ding I	ion	27. Manner of Death Natural 5 ☐ Pendi	28a. Date of Injuing (Month, Dating)		Injury	28c. Injur Worl	yat k? Yes 2 ∐ No	28d. Describ	e now inju	ry occurred	
<u>s</u>	death death ctor: y the	licat	3 ☐ Suicide 6 ☐ Could	dankler (iurv - At home, fa	rm. stre		163 2 110	28f. Location	(Street a	nd Number or F	Rural Route Number,
<u>≤</u> .	al or Attending Physician: T s after death. I Director: After this certificat ed in by the funeral director, pa	Certification:	4 ☐ Homicide determ	building, et	jury - At home, fa tc. <i>(Specify)</i>		, , , , , , , , , , , , , , , , , , , ,		City or	own, State	9)	,
_	To the Hospital of within 24 hours all To the Funeral D completely filled i		29a. Certifier 1 Certify	ring Physician: To the best	of my knowledge	e, death	occurred at the ti	me, date and place	, and due to t	he cause(s	s) and manner a	as stated.
	he Hc in 24 he Fu pletel	edical	(Check only 2 Medica one)	al Examiner: On the basis of and manner st	of examination ar	na/or inv	estigation, in my o	ppinion, death occu	rrea at the tin	e, date an	a piace, and du	e to the cause(s)
	To the vithing complete the com	Ž	29b. Signature and title picertifi	er			29c. Licens			29d. Da	ite signed (Mon	
	11		DAX	m			D3	788P		1!	11 2 2	010
			30. Name and address of person	n who completed cause of	death (Item 23a)	(Type, F	Print)	2 11.	2 1 L	net	~ ~	ID 211 -1
KY	1		31. Date filed (Month, Day, Year)M 1 32 Book	rar's Signature	tu	1 July	JULIE .	DULE	N)	ון ווע	ID 21601
	Sta Registr		NOV	0 4 2010	secon for	9. 1	paren y					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Viola H. Roberts 2010 4: 42 A M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Regional HOSPITAL aurel .aurel Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth Funeral 1 🗆 M 2 🔀 F Months Days Hours Min (Month, Day, **Director** 225-22-1026 90 November Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amay injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2022 Columbia Road, NW, Apt. #118 20009 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Midowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter F. Hancock Cora Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amber Dawn Finnigan / Daughter 3625 S. Mountain Road, Knoxville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Antioch COB Cemetery 11/14/10 Rocky Mount, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Joyle KAY Rogers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Myocardia disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Disease cleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe I ☐ Yes 2 🗙 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation filled in by the ☐ Accidei ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22966 11/10 2010 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print)
Thomas H. Burguieres, MD Laure. Koad 7300 Van Dusen aure. Hospita Emergency Regional haurel 31. Date filed (Month, NOV 1 B Registrar

Michael B. Randall State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Valentine Randal1 2341 hrs Medical Examiner Michael November 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreig Washington, Months Day Hours Min Director October 20,1986 Country) 578-13-6756 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show District of Columbia Washington with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3776 Hayes Street, N.E.; Apt. 2 20019 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 3 Widowed Divorced Yes, Give Yea 1 Yes 2X No specify: Specify: Black Ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry rmit. Pages I and 2 should be filed within 72 hou. portant: If tem 27 is marked orthory or other from: Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Unemployed None 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Michael Hawkins Randa11 Sharon Katrice Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Katrice Valentine (Mother) 3776 Hayes Street, N.E.; Apt. 2; Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Nov.16,2010 1 X Burial 2 Cremation 3 Removal from State National Harmony Memorial Park 4 Donation 5 Other Specify Landover, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians 21. Sign turn of Funeral Service Licensee Inc.;600 Kennedy Street,N.W.;Washington,D.C.2001|1 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED rds, P.O. Box 68760, requires that the death certificate be e IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted Division of Vital Records, nis certificate has been s director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed' death? Com ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Nov 5, 2010 (Month, Day, Year) Subject shot Natural 2250 hrs 5 1 Yes 2 V No Director: Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 6101 Cherrywood Lane, Greenbelt, MD determined (Specify) Sidewalk Homicide 29a. Certifier 1 24] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifing 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 6, 2010 30. Name and address of por on who is impleted cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

			Plea 1 - State Registrar	State of N		d / Depa		t of H	lealth a			ygien	e UTIU	380	80
76	Physic /Medi		Decedent's Name (First, Midd Ruth	le, Last)	ne			keti			2. Date of D Month Novembe	Da		3. Time o	f Death
	Exami		4a. Facility Name (If not institution 336 S. Cannon A		er)		H	ageı	Location			40	County of De Washin		
L	Funeral Director		5. Social Security Number 214–78–7766	6. Sex 7 1 □ M 2 🔀 F	Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D May 4,	irth Pay, Year) 195		rthplace (State Country) aryland	or Foreig
	e Maryland ia-f show	ctor	Usual Residence of Decedent 10a, State 10b. County MD Washi	ngton		, Town or Lo								10d. Inside C	City Limits
	th with the 23a or 28 ust be no	al Director	10e. Street and Number 336 S. Cannon	Ave.			10f. Zip	Code .740				10g. Ci	tizen of What C	•	
980	es 1 and 2 should be filed within 72 hours after death with the Maryland of Heatit and Mental Hygiene. I fitem 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, If Mydical Evaminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Vac Giva	s?] No		Was Deced If Yes, spec 1 □Yes 2	ify Cuba	ispanic Ori n, Mexicar Specify:	igin? (Sp n, Puerto	ecifyYes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify:		
21215-0036		Completed by	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4o	r 5+)		dent's Usua kind of wor DO NOT us Aide	l Occupa k done d e retired	ation Juring mosi)	t of work	ing	16b. K	Cind of Busines:	·	
and 2		Be	12 - 17. Father's Name (First, Middle, Robert C. Shra	•		пеац	Arue				e (First, Middle J. Male			<u> </u>	
Baltimore, Maryland		ဥ	19a. Informant's Name/Relations Kenneth E. Ric	ship (Type. Print)			_		and Numbe	er or Rur		ber, City	or Town, State,		
more,	Pages 1 and 2 s nent of Health a int; If item 27 is iry or other trau		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		.6	ace of Dispo emetery, cren t Have	sition (Nam natory or ot	e of her place	9)	(Date	20c. L	ocation - City o		
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service S. Mark		Res	22	. Name an	d Addres	s of Facilit	y Res	t Have	n Fui	neral C	hapel	42
	Physician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. CH	line.	Do not ent	er the mode	of dyin	g, such as	cardiac	or respiratory			Approximation interval Ber Onset and	te tween
760,	e be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a conseque										
. Box 68	death certifical e attending phy d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1	2 Fetal	death 3 □] Ectopic pr] Other <i>(s</i> pe		,				23d. Date of do Month		Year
rds, P.	quires that en signed b uld be deta	þ	Part II. Other significant condition	ons contributing to death			nderlying ca	use give	n in Part I.				. /	to the cause of c	
al Reco	y stcian: The law requii lis certificate has been s director, page 2 should	Completed		***			_	-			24a. Was auto perfe 1 □ Yes	psy ormed?	prior to death?	utopsy findings completion of c	available ause of
Z Z	/slcian: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 □ E	EP/Outpation	+ 3□00	Othe	F-		(Check only		. To::		
Division of Vital Records,	Attending PP or death. ector: After they the by the funeral	Certification: To	27. Manur of Death 1 Natural 5 Pendin 2 Accident Investit 3 Suicide 6 Could determ	g 28a. Date of Ir (Month, E	ijury Day, Year)	28b. Time of Injury	M 28	ic. Injury Work 1 🗆 Y	at	No	28d. Describe	how inju	nd Number or F	ecity) Rural Route Num	nber,
Ω	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Cer	29a. Certifier (Check only one) 1 Certifylr 2 Medical	ng Physician: To the bes Examiner: On the basis	at of my know of examination	ledge, death	occurred a	at the tim	ne, date an	d place, th occuri	and due to the	cause/s	and manner	as stated. e to the cause(s	s)
	To the within To the Comple	Mec	29b. Signature and title of certifie	and manner s	stated.		1		number	4			te signed (Mon	th, Day, Year)	00/0

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATT BECKWITM MD

31. Date filed (Month, Day, Year)

DEC 06 2010

32. Registrar's Signature

DEC 06 2010

1110 Medical Campus Rd Hagerstown Md 217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Joseph Robinson 3 - 201 Medical November 19,2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Larkin Chase Nursing Center Bowie Prince Georges 8. Date of Birth
(Month, Day, Year)
T11 1 V 28,192 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 1 🔀 M 2 🗆 F Months Hours Country) Director 248-20-6591 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No MD PG Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4316 Rockport Lane 20720 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 1943 Specify: Completed Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David Robinson Sarah Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4316 Rockport Lane Clara Robinson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20720 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Henwood Cemetery | 11/27/10 | Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Renal Insufficiency 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hypertension has autopsy performed death? 2 1 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 19 No ᇛ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Fractioner: To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completed fil 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D45217 person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

M. D. 62 2. Registrar's Signature

Ajavi

,6201 Greenbelt Rd., College Park, MD 20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11/14/2010 11:00 P M **JAMES** RIDDICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PINEVIEW NURSING HOME CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 **X** M 2 □ F (Month, Day, Year) 9/23/1944 Yrs. **Director** 277-56-4277 66 Usual Residence of Decedent or 28a-f shov 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 3940 Bexley Place # 408 20746 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ William Riddick Elma Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is rinjury or other trau Howard Riddick / Brother 4605 Calais Street Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 x Burial 2 Cremation 3 x Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 11/20/2010 | Norfolk, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityAlexander S. Pope Funeral Home 10105 2617 Penn. Ave. SE Washington, DC 20020 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ surintic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an filled in by the funeral director, page 2 performed? 1 🗌 Yes Yes 2🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? Natural Natural 5 Pending Μ 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in this opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

11761 Livingston Road Fat WASHington, MD an 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

linen

T. Tonne

29b. Signature and title of certific

D 75206

November 16,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 3803

		1-For State Certificate Registrar Certificate		Reg. I	No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami	iner	Pamela Ransome	The City Town and ageting of Death	Month Da November 15	5, 2010 4c. County of Death	1700 hrs
		Facility Name (if not institution, give street end number) Prince George's County Hospital	4b. City, Town, or Location of Death Cheverly	1	Prince George	's
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (N		nplace (State or Foreign
Director		257-17-3369 1 M 2 X F 44 Y	Yrs. Months Days Hours Min	March 18	3, 1966 Mas	ntry) ssachusetts
any		10a. State 10b. County 10c. City, Town or Loc	cation		T	10d. Inside City Limits
	'n	Maryland Prince George	Capitol He	ights		1 X Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number	10f. Zip Code		Citizen of What Count	try?
th the Maryland 23a or 28a-f sho notified at once	Ö	7313 Central Avenue	20743		United St	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Hel and Mental Hygiene. It is tem 27 is marked other than "natural", or items 23a or 28a-f she mit. If item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. V Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	
after	by F	or Dates:	Yes 2 X No specify:		-,,-	ack
hours af fnatural Examin		during	dent's Usual Occupation (Give kind of v most of working life. DO NOT use reti		b. Kind of Business/In	dustry
36 nin 72 e. than	ple	Elementary/Secondary (0-12) College (1-4 or 5+)	Office Manager		ъ.	
sed with	Completed	17. Father's Name (First, Middle, Last)	<u> </u>	First, Middle, Maid	Privat den Sumame)	<u>.e </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Walter Jordan		Helen T	remble	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Heath and Mental Hygiene, Important: If item 27 is marked other than " injury or other traumatic event, the Medical	2		ling Address (Street and Number or F			
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat			3 Central Avenue osition (Name of cemetery,	Capitol Date 20	Heights, M. Oc. Location - City or T	Id. 20743
Ore of He If its		1 Burial 2 Cremation 3 Removal from State crematory or	other place) Nov	. 27.		
timent rtment rtant:	- 3		Harmony [20]	10	Landover,	
Baltil permit. Departm Imports injury o			Name and Address of Facility Ste			
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter				Approximate Interval
/Medical £xaminer		failume. List only one cause on each line. Immediate Cause (Final disease a. Infective endocard	itis			Between Onset and Death
xammer		or condition resulting in death) Due to (or es a consequence of):				
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876(ificate ig phy s the b	n/Me	3b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna	- 1	23d. Date of delivery Month Da	ıy Year
Box 687 death certific the attending p	sician/	past 12 months?	Other (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
Bo re dear	Phys	1 Yes 2 No 9 Unknown 9 Unknown				
ires that the signed by be detach	by F	Part II. Other significant conditions contributing to death but not resulting in the	aunderlying cause given in Part I.		co use contribute to the	
ds, duites				24a. Was an		opsy findings available
COF law re has b	Completed	-		autopsy performed	prior to co	mpletion of cause of
tal Recian: The		25. Was case referred to medical	26 Blane of Death (Check	- Land	No 1 Yes	2 No
Division of Vital Records, rate dar Attending Physician: The law requires at a faster death. After this certificate has been sited in by the funeral director, page 2 should be	Be (examiner? Hospital: A leasting of ER/O testing	26.Place of Death (Check of Donald 1		idence 6 Other:	
of V ig Phy fler th	٦. To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		
On tendin sath. or: A	itior	1 Katural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No			
VISI or Att fter de Direct in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Stree or Town, State)	et and Number or Rura	I Route Number, City
Spital lours a filled	Certification:	4 Homicide determined (Specify)		Or Town, State,		
Division of Vital Records, P.O. Box 68760, within 24 hours after denth expected within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investign and manner stated.				
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Monti	
		(Cataleno	O.C.M.E.	N	ovember 16, 201	0
		3. Tame and address of person who com Teled cause of death (Item 23a)	on Street Politimers MD 040	01		
	o la		nn Street, Baltimore, MD 212			1.1
St Regis	tate trar	31. Date filed (Month, Day Year) Server 32. Registrate Signature NOV 2 4 2010				

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		For State Registrar	State of M	-	-	artment of I tificate of I		d Mental		ne No. 0	1.0	38084
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Physicia Medi	cal	Horace Eve						Nover Nover		15, 2	Year 010	4:10 PM
Exami	ner	4a. Facility Name (if not institution, give	e street and number)			4b. City, Town, o				4c. County		
Funeral	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under			_If Under 1 Year		Hrs. 8. Date o				nplace (State or Foreign		
Director		217-42-8529	I X] M 2 □ F	84	rs.	Months Days	Hours N	din. (Month August	, Day, Yea : 15,_	ar) 1926	Cou	ntry) Maryland
ind show	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	cation						10d. Inside City Limits
Maryla 28a-f stified	rect	Maryland St. Ma	ary's			Mecha	nicsvil	11e				1 ☐ Yes 2 🖾 No
h the	Funeral Director	10e. Street and Number				10f. Zip Code			10g.	. Citizen of V	Vhat Cou	intry?
ath wit	nner	39010 Lyons Lan	e12. Was Decedent E	Suprin II C	112 1/	Vas Decedent of H	20659	/Cif- V	N/a	1	USA	
6 ter de: or ite	by F	1 🔀 Never Married 2 🗆 Married	Armed Forces? 1 ☐ Yes 2 🔀		l1	Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)		k, White,	ican Indian, , etc.
UUCS urs aff turral",	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🔀 No	Specify:			Specify:	Whi	.te
72 ho n "na Aedica	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give I	lent's Usual Occup kind of work done (O NOT use retired)	during most of v	working	161	o. Kind of Bu	ısiness Ir	ndustry
X1X within giene. er tha							Far	rming				
ING 21215-UU36 a filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Mic	idle, Maid	len Surname)	
ryla ould be d Men marke	-	Vernon Jerome Rice Elizabeth Louise Thornant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State						0.00				
Ma 12 shouth and the a		William V. Lyon		1.		Box 68,					tate, Zip	Code)
of Hee		20a. Method of Disposition		20b. Place of	Dispos	sition (Name of natory or other place		Date	200	. Location -	City or T	own, State
Page ment tant: h		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1		copal Ceme	11000	ember 18, 2010		wport	, Ma	ryland
Baltimore, Maryland 21215-UU36 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	Handing		22	. Name and Addre	ss of Facility M	Mattingle P.O. Box	y-Gard 270, I	diner Fu Leonard	unera town,	1 Home, P.A. MD 20650
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused	the death. Do no	t ente	r the mode of dyin	g, such as card	diac or respirator	y arrest,			Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	. 5	rati	4	< miz						Onset and Death
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he death or y the atten tched for u	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Mor	nth	Day Year
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or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2 %		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of injur (Month, Day	y 28b. Tir		28c. Injury work	y at ?			jury occurre		
Attendir r death. cctor: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		ny - At home, farn	n etra		Yes 2 □ No	206				I De la Maria
tal or A		4 ☐ Homicide determined	building, etc		n, sue	et, factory, office			Town, Sta		r or Hura.	I Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral birector: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination and/or	investi	gation, in my opinio	on, death occurre	ed at the time, da	ate and pla	ace, and due	to the ca	use(s) and manner stated.
To t with To tl		29b. Signature and title of certifier	Der-	Le 10		29c. License			29d.	Date signed	(Month,	Day, Year)
		1-00.					00500	0	N	ovember	16,	2010
pme		30. Name and address of person who all Leon W. Berube, MD.	completed cause of de 28170 Old Vi				11e MD	20659				
Sta		31. Date filed (Month, Day, Year)	32. Regis ra	r's Signature			LIU PIU	20037				
Registra	ar	MOV I 6	2010 Den	wa B	. 16	Darke						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 21 Month Year 2010 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** rdtow lona 8. Date of Birth (Month, Day, Ye October 31 9. Birthelace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 🗆 M 2 🖾 F Days Mary land 220-40-4314 66 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 K No Callaway St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20620 USA 20625 Point Lookout Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ဂ္ Thelma Newton William McGee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20625 Point Lookout Road Callaway, Maryland 20620 John M. Ridgell/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 24, Charles Memorial Gardens 2010 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signatore of Funeral Service Lices P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
2 4 1 TOULS Immediate Cause (Final KESPIRATORY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YEARS CHRONIC OBSTRUCTIVE PULMONARY DISEASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day been signed by the attershould be detached for Other (specify) Pregnant at time of death Unknown s, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Record 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director; After filled in by the funer (Month, Day, Year) Natural injury work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [3 [only one) 29b. Signature and title of certifier NOVEMBER 22,2010 26344 ica y Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARDTOWN, MARYLAND ST MARY'S HOSPITAL MATRICIA GURLY 32. Registrar's Signature 31. Date filed (Month, Day, Year, State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Debra Kay RICHARDSON 2010 November 2213 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Maryland 20 Manor Drive, Apt. 103 Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Aug • 5 1 □ M 2 🗶 F Days Months Hours 56 Country)
Maryland 1954220-64-6337 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 20 Manor Drive, Apt. 103 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ☐ Never Married 2 🔀 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced White Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Cook Nursing Facility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Luther White Nancy Lee Janes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> John H. Richardson - Husband</u> 20 Manor Drive Apt. 103 Hagerstown. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 11/20/10 Hagerstown, Maryland 21. Signatur Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Chron disease or condition resulting in death) Due to (or as a consequence of):

Physician,) Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a'f sho amortant: if item 27: is marked other than "natural", or items 23a or 28a'f sho injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by Be <u>ا</u> Certificate:

Medical

Sequentially list conditions,	b. 				
cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to for the tribune equaties on:				
resulting in death) Last	Due to (or as a consequence of): d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of del Month	livery Day Year	
	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
Nabetes M	teart Failure	1 Nes	2 □ No 3 □ Pr	robably 4 🗆 Unkno	wn
Congestive A	teart failure	24a. Was an autopsy performed?	prior to death?	topsy findings availab completion of cause c	

26. Place of Death (Check only one)

Hagerstown

28c. Injury at work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by the a page 2 should be been has certificate : After this certificate funeral director, [neral Director: A within 24 hours a

To the Funeral C

completed filled

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred to the control of the con	 In MV opinion, death occurred at the time, date 	and place, and due to the cause(s) and manner stated
9b, Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

1 Inpatient 2 I ER/Outpatient 3 I DOA

28e. Place of Injury - At home, farm, street, factory, office

28b. Time of

manner as stated. ned (Month, Day, Year) November 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing ton County 747 Northern Avenue Synthia Kuthner-Sands we Hospice of Washing ton County 747 Northern Avenue

JH-2 State

Registrar

Ernthia Kuttner-Sands up

5 Pending

Investigation 6 Could not be

determined

Hospital

28a. Date of injury (Month, Day, Year)

nother Kutther-Sand no

25. Was case referred to medical

1 ☐ Yes 2 ₺ No

27. Manner of Death

Natural

4 Homicide

☐ Accident

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38087 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 12, 2010 Winona V. Reves 2:08 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clinton Prince George's Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 29 Yrs. 8. Date of Birth (Month, Day, Year) Aug 29, 1981 **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 615 09 4337 Months Days Hours Min. 1 □ M 2**XX**F Director Philipines Usual Residence of Decedent 28a-f shov 10a State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland 1 Yes 2 A Clinton 6 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 6320 Danner Drive 20735 United States 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1XXNever Married 2 Married 1 ☐ Yes 2 No If Yes, Give XX Baltimore, Maryland 21215-0036 1√√√ Yes 2 □ No Specify: Completed 3 Widowed 4 Divorced Specify: Filipino Filipino Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha iury or other traumatic event, the № College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilfredo Reves Flerida Nona Victa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilfredo Reves (Father) 6320 Danner Drive, Clinton, MD 20735 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 1 Nurial 2 Cremation 3 Removal from State permit. Page Department o 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Nov 23,2010 Cheltenham, Maryland of Funeral Salvive Lice 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ENCEPHALOPATHY ANOXIC if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Director: After this certificate I performed 2 No Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation thin 24 hours after developmental Director impleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2133

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Surgatts Road Clinton

MD

29c. License number

D0064986

2010.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Deretha 14, Mav Robison November 2010 2018 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min, 216-18-1163 10/09/1923 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No MD Allegany Cresaptown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14507 Pioneer Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ♥ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Frederick Knippenberg Anna Rebecca McCarty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suella Habersack / Daughter 14507 Pioneer Street, Cresaptown, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 11/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease 10 vears Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Exercity and Dece.

/Medical

Directo

Funeral

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or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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neral Director: / To the Hospital o within 24 hours af To the Funeral Di completely

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier (Check only one) 29b. Signature and title of certific

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28a. Date of Injury (Month, Day, Year)

29c. License number

D36766

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

21502

November 15, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD

NOV 18



32. Registrar's Signature

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

			State		artment of Health and N rtificate of Death	1ental Hygie	ene	00000
			Registrar 1. Decedent's Name (First, Middle, Last)		uncate of Death	2. Date of Death	j. No.	1381189
	Physicia Medi	cal	James Edward		rds, Sr.	Month Month	Day Year	3. Time of Death
1	Examir	ner	4a. Facility Name (if not institution, give street and number Western MD Regional Medio		4b. City, Town, or Location of Death Cumberland		4c. County of Death Alle	gany
	uneral irector		218-34-4573 1 [™] 2 □ F	Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 10/25/1	ear) Cou	hplace (State or Foreign intry) Yland
Б	how	=	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		1141	
faryla	with the Marylar s 23a or 28a-f sl ust be notified	ect	MD Allegany		Cumberland			10d. Inside City Limits 1 🕅 Yes 2 □ No
the M		ă	10e. Street and Number		10f. Zip Code	100	a. Citizen of What Cou	
with		Funeral Director	700 White Avenue		21502		US	,
36 after death	l", or item kaminer m	Completed by Fur		s? □ No 1957–	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Z1Z15-0036 within 72 hours after giene.	atura cal E	etec	3 Widowed 4 Divorced Year or Dates 15. Decedent's Education	s. 1902	lent's Usual Occupation		Specify:	White
672 1727 n	Medi	直	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	(Give k	ient's Osdal Occupation kind of work done during most of workin DNOT use retired)	ng 16	b, Kind of Business I	ndustry
Vithi Vajene	t, the		12		onry Contractor		Union	
Maryland 2 should be filed th and Mental Hv	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire M27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) John William	Richards	18. Mother's Name Florence	(First, Middle, Maid e Ei	den Surname) mma N	Velson
b, Mar nd 2 shou lealth and			19a. Informant's Name/Relationship (Type, Print) Barbara J. Richards / Wif		g Address (Street and Number or Rural White Avenue, Cum			
altimore, mit. Page 1 and partment of Hea			20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Davis Mem	sition (Name of Date) atory or other place) 1. Cemetery 11/22	1	c. Location - City or T Cumberland	
Dan	Importany in		21. Signature of Funeral Services Licensee		Name and Address of Facility Ada)4 Decatur Street,			Home, P.A.
			23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do not enter	r the mode of dying, such as cardiac or	respiratory arrest,		Approximate
	ician/	i i	Immediate Cause (Final disease or condition		barachnoid	hemor	mhas	Interval Between Onset and Death
	edical miner			as a consequence of):),	12
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rted		Examiner	cause. Enter Underlying Cause (Disease or iinjury					
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Attending Physician: The law requires that the death certificate be executed at death.	attending pt for use as th	Physician/Me		h 2 🗌 Fetal death 3 🔲	Ectopic pregnancy Other (specify)		23d. Date of deliv	
he de	detached	hysi	1 Yes 2 No 4 Pregnan 9 Unknown 9 Unknown		Other (specify)		Worth	Day Year
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quires .	should be	ted				1 🗆 Yes	2 🗌 No 3 🗌 Pro	bably 4 Unknown
aw re	as be	Completed				24a. Was an autopsy		psy findings available mpletion of cause of
The	page	9				performed	? death?	
ician:	is certific director,	0	25. Was case referred to medical examiner? Hospital:		26. Place of Death (Check of			
Phys	ral dir	2	1 Yes 2 No Hospital: 1 Inpa 27. Manne of Death 28a. Date of in	atient 2 ER/Outpatient	1		6 Other (Specify)
the ding	fune	Certificate	1 Natural 5 Pending (Month, D	Day, Year) 266. Time of injury	28c. Injury at work? M 1 □ Yes 2 □ No	3d. Describe how in	jury occurred	
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talor rs afte	ed in Circ	္တ္က	building, e	etc. (Specify)		City or Town, Sta	ate)	
To the Hospital or Attending Phys within 24 hours after death.	ted fill	Medical	29a. Certifier 1 Certifying Physician: To the best	i examination and/or investig	ation in my opinion, death occurred at #	a time date and alc	acc and due to the ear	100/0) and manual at at at
the ithin 2	omple.	ž ,	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowledge, de	eath occurred at the time, date and place,	and due to the caus	se(s) and manner as st	ated.
		ľ	250. digitatore and the of collinsty		29c. License number	I .	Date signed (Month, I	*
	37		30. Name and address of person who completed cause of	death (Item 23a) (Type Pri	D 36766	/ /	Voien bin	12/50/1
n	LS				e, Cumberland, MD	21502		
	State	_		trar's Signature	w .			
R	egistra	r	NOV 19 2010 January	- p. Hours				

				Please Type or Print in Black In State of Maryland / Depa	artment of Health and M		ene	
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		Physici	an/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	J. Tille of Dea	ıth
	- North	Medi		Alan Stetson Reeves, Sr		November	1 0013	A ^M
	1	Exami	ner	776 Warburton Road	4b. City, Town, or Location of Death $E1kton$		4c. County of Death Cecil	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or For	reian
	1	Director		215-56-0185	Months Days Hours Min.	OCT 8,	.951 Maryland	
		and show at	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Lin	mite
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		a or 2 be no	٥	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?	
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S	21215-0036	safte ral", c Exam	d b	3 Widowed 4 Divorced 1 Mayes 2 No If Yes, Give 1974 1	☐ Yes 2 🎇 No Specify:		Specify: White	
ALAN REEVES	2-0	hour "natu dical	olet (15. Decedent's Education (Specify only highest grade completed) (Give k	ent's Usual Occupation	16	6b. Kind of Business Industry	
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Z	5	Hygie Hygie other int, th	Be C	17. Father's Name (First, Middle, Last)	nolsterer		Aircraft	
AL/	au	be tilk ental ked c	2	Orville W. Reeves		e (First, Middle, Mai	iden Surname)	
	Maryland	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Anna Sp Address (Street and Number or Rura		ity or Town State Zin Code)	_
	Σ	nd 2 s ealth a n 27 i			Varburton Road, El			
	Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		20a. Method of Disposition 20b. Place of Dispos	ition (Name of		Oc. Location - City or Town, State	
	ţi.	t. Page tment o rtant: If ijury or		4 Donation 5 Other (Specify)	n Cemetery 3, 2	010	Cherry Hill, MD	
	Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22.			for Funerals, P.A. Elkton, MD 21921	
		_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter				-
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	Division of Vital Records, P.O. Box 68760 all or Attending Physician: The law requires that the death certificate by	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE:				
	6 7	tendir or use	ian/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery	
	80	the at	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month Day Year	
	O. E	ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e Did tohac	co use contribute to the cause of death?	
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	n O'	h. After funer	Certificate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	8d. Describe how in	njury occurred	
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	Divi	s afte		4 ☐ Homicide determined building, etc. (Specify)	i, radioty, office	City or Town, St	t and Number or Rural Route Number, tate)	
	lospit	4 hour	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occording to the control of the pasis of examination and/or investigation.	cured at the time, date and place, and	due to the cause(s	and manner as stated.	_
	the t	thin 24		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, dea	ath occurred at the time, date and place	he time, date and pl , and due to the cau	ace, and due to the cause(s) and manner sta se(s) and manner as stated.	ated.
4	P _C	70 CO		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
•				30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	10000G	5	11/2010	
				Martha Hosford, M.D., 111 W. High Str		Elkton M	D 21921	
	1 %	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature			L1761	\dashv
X	Dur	Registra		Dec 00 2010 peneva B. A.	arkel			\Box
3	UHMHU	17 Rev 7/20	109		Δ1			
17	_			ORIGIN	AL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2010 Gail M. Renner /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical hescheate Harford Hours Min. 12 Month Day (13) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 □**X**F Months Days 218-70-2921 50 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examinations the rothling at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 □ No Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3576 Day Road 21034 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Parts Maker Manukactorina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Gill Leischmen Lelia Marie Vance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3576 Day Road, Darlington, Maryland 21034 Robert Worthington (Boyfriend) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc 11/29/2010 | West Chester, PA ^{22.} Name and Address of Facility Zellman Funeral Home, P.A. atere of Funeral Service Licenses <u> 123 S. Washington St., Havre de Grace, MD 21078</u> 23a. Part 1. Enter the disease, of complica shock, or heart failure. List bely on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 2-11No 2 🖪 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

the death certificate be execute attending physician certificate Physician: After this funeral the Hospital or Attending n 24 hours after death.

e Funeral Director: Afte bletely filled in by the fun

Medical within 2. State

Registra

4 Natural

2 Accident

3 ☐ Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and title of ertified

5 Pending

investigation

6 Could not be determined

	/ /
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2
MATT WACH MAN 407 SAUR CHOWACE HAVE	11/200- 10
1 17 1 11 11 11 11 11 11 11 11 11 11 11	IN CHUROST
31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Server B. Barker	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

←Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2 🗆 No

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or State of

Print in Black Indelible Ink. Ensure All Copies Are Legible. f Maryland / Department of Health and Mental Hygiene	00002
f Maryland / Department of Health and Mental Hygiene	30034

		1- For State Certificate of Registrar	•		g. No.				
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month November		3. Time of Death 0020 hrs			
yiedicai Examin	G.		o. City, Town, or Location of Death		4c. County of Death				
		St Mary's Hospital	Leonardtown, MD		St. Mary's				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_		thplace (State or Foreign untry)			
Director	-	337-27-7972 1 1 MM 2 F 38 Yrs. Usual Residence of Decedent		August	16, 1972 M	aryland			
any	ŀ	10a. State 10b. County 10c. City, Town or Location							
*	اة	Maryland St. Marys Lexington	Park			1 Yes 2 No			
ith the Maryland 23a or 28a-f sho notified at once	rect	1	10f. Zip Code		g. Citizen of What Cour	ntry?			
ith the s 23a o	흥	2096/ Moongate Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	20653 Decedent of Hispanic Origin? (Sp		15 A	can Indian, Black,			
r items	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes 2 No	White, etc.						
after call, on iner m	by F	3 Widowed 4 Divorced If Yes, Give Year 1 1	res 2 No specify:		Specify: Bla				
2 hours	ted		s Usual Occupation (Give kind of w st of working life. DO NOT use retir		16b. Kind of Business/I	ndustry			
D36 thin 7.	Completed	12 4 Program	n Manager 18.Mother's Name	Ì	Dept. of 1	Vary			
21215-0036 Mental Hygiene marked other than "natural event, the Medical Examin		17. Father's Name (First, Middle, Last)							
2121 uld be f Mental marke r event.	e P P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or R	Crac D	per City or Town State	Zip Code)			
and sho	-		Moongate Ln on (Name of cemetery,						
o – = = -	Ī	20a. Method of Disposition 20b. Place of Disposition Buriel 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or othe	on (Name of cemetery, r place)	Date	20c. Location - City or	Town, State			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Putney Fa	mily Cem. Nov.	28,2010	White Plai	ns, VA			
Baltimor permit. Pages Department of Important: If		4 1			East St. B.	L. Ketane VA			
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Hawkes Son F. mode of dying, such as cardiac or			Approximate Interval			
/Madical Examiner		failure. List only one cause on each line. Oxycodone and alcohol Immediate Cause (Final disease a. Oxycodone and alcohol	intoxication			Between Onset and Death			
ZAGIIIIISI		or condition resulting in death) Due to (or as a consequence of):							
	<u>اة</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
70	Examiner	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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760, icate be executed physician and the burial - transit	Medical	X UNPENDED	G910 12/13/10 TT	Γ					
876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	I death 3 Ectopic pregnar	ncy	23d. Date of delivery Month	day Year			
Box 687; death certific	Physician/		r (Specify)						
that the denet by the detached f		Part II. Citier significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
ires that il signed by	Completed by			1 Yes	2 No 3 Prob	ably 4 🗹 Unknown			
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this settificate has been si and in by the funeral director, pgc 2 should be its after the set of the control of the contro	ള			24a. Was ar autops	y prior to c	topsy findings available ompletion of cause of			
ian: The law	Ē			perform 1 ✓ Yes 2		s 2 No			
Vital Pysician: ysician: his zertifi	8	25. Was case referred to medical examiner? Hospital: 4 Inspital: 4	26.Place of Death (Check of Donald Check of Do						
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ivision or Attendath after death Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (St	reet and Number or Rulete) 20961 Mod	ral Route Number, City ongate Lane			
Dispital hours and filled		4 Homicide determined (Specify) Found: resi	dence	Lexingt	on Park, M	D			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, p. gc 2 should be detached for use as the burial - transfer.	<u>ا</u> ق	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation							
To Your	ĕŀ	and manner stated. 29b Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)			
		(Lawnkeus)	O.C.M.E.		November 22, 20	110			
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 2120						
Sta	te								
Registra	ar	31. Date filed (Month Day Year) 6 2010 32. Registrar's Signature & Apar	Kand						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BONITA BAER REED November 1:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18 Valley Lake Place, Apt C Cockevsville Baltimore County Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign OCT 6, 1952 213-60-7933 Months Days Hours 58 Director Maryland Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Cockeysville 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Valley Lake Place, Apt C 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🖳 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ Louis Baer Hilda Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other t 5802 Farmgate Court, Frederick, MD 21703 Christopher Trammel.Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery Nov 30, 2010 Frederick, Maryland Signature of Funeral Service Licensee 22 Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ 10 M disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordershing Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month 9 Unknown Unknown been signed by the should be detach-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page performed^a Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after user. The Funeral Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Paul Celano,

31. Date filed (Month, Day, Year)

MD,

32. Registrar's Signature

6569 North Charles Street, Suite 205, Towson, MD 21204

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Jeffrey Dorse Richmond November 0918 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death E1kton Cecil 259 Sycamore Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F NOV"129", Year 960 Maryland 216-66-8679 49 Director Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 💢 No Cecil E1kton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a o Examiner must be Funeral 259 Sycamore Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: "natural". Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Concrete Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Dean Garnet Eugene Richmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen D. Richmond/Mother 259 Sycamore Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Memorial Park 2010 <u>Elkton, MD</u> 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Weck neumoni disease or condition Medical resulting in death) Due to (or le a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗶 Residence 6 🗌 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death only one 29b. Signature and title of dertifier 29d. Date signed (Month. Dav. Year) 29 Gopet mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cathedral St. Elkton 21921 CARLO GUPEZ 138 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pines. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician Medica Examine

Funeral **Director**

		For State Registrar		State of M	1arylan	•	artmen <i>tificate</i>			and M	ental Hy	gien Reg. 1	00	10	32005
icia	n/	1. Decedent's Name (First, LEROY REINBU		·							2. Date of De	ath		o lo	3. Time of Death
edic min		4a. Facility Name (if not inst					4b. City, 1	Town, or Lo	cation c	of Death			c. County		05:16A ^M
		NATIONAL NAV 5. Social Security Number	JAL ME			et hirthday	BETI If Under	HESDA	Under	24 Hrs	9 Date of Die		MONTG	0. 0146	I (D4-1 F
rai tor		426-78-1629 TX M 2 F 87 Yrs. Months Days Hours Min. (Month, Day, Year) Aug. 25,1923									Gount	D.C.			
	lor	Usual Residence of Decede 10a. State 10b. C		-	10c. City	, Town or Lo	cation					_		10	0d. Inside City Limits
	Director		Monto	gomery	Si	lver									1 🗌 Yes 2 🗷 No
	eral C	10e. Street and Number		. Manala	D 3 4	#221	10f. Zip	Code 2 0 9 0	6			109. 0 U.S.	Citizen of V A	Vhat Coun	try?
	by Funeral	11. Marital Status 1 Never Married 2								k, White, e	rtc.				
	leted	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1948-75													
	Completed		(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) (Give kind of work done during most of working life. DO NOT use retired) US Coa												
	Be	17. Father's Name (First, Mid	ddle, Last)	4			apta		. Mothe	er's Name ((First, Middle,	Maide	n Surname)	
	မ	LeRoy Rei				Т					inia				
		19a. Informant's Name/Rela			ife rg	19b Mailir 3 0 0 5 Silv	g Address er S	(Street and Leis prin	<i>Numbe</i> ure g,	r or Bural I Wor MD 2	Poute Number 10906	v d	or Town, Si	32 I	ode)
	i i	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O			20b. Pl	lace of Dispo emetery, cren teof ceme	sition (Name natory or oti Hea terv	e of her place) ven		No v 2			Location - lver	-	
once.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility ollins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD													
an/ cal ner	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury that initiated events resulting in death) Last SEPSIS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Onset and Death			
	Σ∣	d											ry Day Year		
	হ	Part II. Other significant co	onditions co	entributing to death	out not resu	ulting in the u	nderlying ca	ause given i	n Part I						e cause of death?
İ	Completed	24a. Was an 24b. Were a autopsy performed 2 death?									rior to com	sy findings available npletion of cause of			
- 1	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ▼ No	L	Hospital:				Othor		h (Check o					
	Certificate: To	27. Manner of Death 1 ▼ Natural 5 □ F	Pending nvestigation	28a. Date of inju (Month, Da	iry :	ER/Outpatien 28b. Time of injury		c. Injury at work?		28	e 5 Resid				
			Could not be letermined	28e. Place of Inj building, et			et, factory,	office		28	3f. Location (S City or Tow			r or Rural F	Route Number,
	Medical	(Check 2 Med only one) 3 Cert	lical Examii tifying Nurs	i⊏ian: To the best of ner: On the basis of e e Practioner: To the	examination	and/or invest	igation, in m	ly opinion, d	eath oc	curred at th	ne time, date a	nd plac	e, and due	to the caus	se(s) and manner state
		29b. Signature and title of co	-	Come	e			License nur D5781				0	ate signed		ay, Year) , 7010
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK D. CORRIERE, LCDR, MC, USN NATIONAL NAVAL MEDICAL CENTER, BETHESDA, M													
State stra	-	31. Date filed (Month, Day, Y		32. Registr											
				1 4 - 1 -		- Indian									

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 8:40 11/15/2010 Medical RONALD M. SIMMS 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 4/13/1947 Days Months Hours Min Director 577-62-9336 63 Washington, DC Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 No DC Washington 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4339 BOWEN ROAD SE # 206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: "natural", 3 Widowed 4 Divorced Completed Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72. h and Mental Hygiene. **7 is marked other than "**r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chauffer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Yeldell Lorraine C. Simms 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah C. Miller / Sister 324 F Street NE Washington, DC 20002 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2010 Washington, DC 22. Name and Address of FacilityPope Funeral Homes, P.A. Signature of Funeral Service License MO LUIS 5538 Marlboro Pike Forestville, Maryland 23a. Pa. 14. Ever the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List very one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ☐ Unknowr 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate Yes 2 🗷 No 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No ည 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hin 24 hours after death. the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 2 2

R 2

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 9 2010

32. Registrar's Signature

HAKA

who completed cause of death (Item 23a) (Type, Print)

7325A

HAMOVER

PARKNAY GREENBELT MARYLAND 20170

			1 - State of Maryland / Dep Registrar Ce	artment of Health and I		ne . Nd 2 0 1 0	38097
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Mary E	Savoy	Month 11—	7- 10 Year	10:34a M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	
			Fort Washington Rehab.	Fort Washing	aton	Prince G	George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	g. Bir	thplace (State or Foreign
	Director		216-70-9961 1 M 2 F 84 Yrs.	Month's Days Hours Min.	(Month Day, Ye	926 Mar	yland
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ncation			10d. Inside City Limits
	rylan I-f sh ied a	cto					1 🕅 Yes 2 □ No
	or 286	Dire	Maryland Prince George Fort Wa	ashington 10f. Zip Code	100	. Citizen of What Co	
	ith th	rai			109		outiny:
	ems	Funeral Director	12809 Halwood Pl 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20744 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	rican Indian.
ယ	or it		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
8	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify:Bla	ck
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anc	be file ental F ked o ic eve	To E	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		37 7
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Ė	Charles Robins 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	son Max ing Address (Street and Number or Rui			Neal
ĭ	2 4 7 2			09 Halwood Plac			
ē,	and Hea em the		20a. Method of Disposition 20b. Place of Disp	osition (Name of		c. Location - City or	
9	0		1 🔀 Burial 2 □ Cremation 3 □ Removal from State	matory or other place)	5/10 Wa	aldorf M	arvland
Baltimore,	permit. Page Department Important: I any injury or once.	1		Name and Address of Facility	3710 110	iluoll	ar y z a n a
m	ang Per	1	Therese real	Adams Funeral H	ome Pa,A	Aguasco	, MD 20608
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Na Comment	Approximate Interval Between
-	Hysician/	8 1	Immediate Cause (Final disease or condition	Cancer			Onset and Death
	Medical 		resulting in death) a. Due to (or as a consequence of):				33
		7	Sequentially list conditions, b.				
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or minury				
	ecute and Il-tran	Еха	that initiated events resulting in death) Last C				
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$\overline{}$	ificate ig phy as the	Med	ILE CENTRAL E.				
89 ×	endin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the part 12 modes 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of de	
Вох	death	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		Month	Day Year
o.	at the d by tl etach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tobac	co use contribute to	the cause of death?
ω, σ.	requires that the de been signed by the should be detached	d by		, , ,		_/	robably 4 🗆 Unknown
ğ	requi	lete			24a, Was an	24b. Were au	topsy findings available
Records,	has has	Completed			autopsy performed	prior to death?	completion of cause of
<u> </u>	sician: The certificate rector, pag	O	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2	Ino 1 ⊔ Yes	2 No
VIta	ysicia s cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	- Other:	ome 5 Residence	e 6 Other (Spec	ifv)
o	ig Ph		27. Manner of Death 28a. Date of injury 28b. Time o injury 1. Natural 5 □ Pending (Month, Day, Year) 28b. Time o	f 28c. Injury at work?	28d. Describe how in	njury occurred	
ou	endir sath. or; Af he fu	fica	1 Hatural 5 Pending (Nontri, Day, Year) Injury 2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
Division of Vital	or Att fter d irect n by t	Certificate:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St		ral Route Number,
Ō	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,		29a. Certifier 1 Oertifying Physician: To the best of my knowledge, death	accured at the time, date and place, a	ad due to the equee/s	and manner as etc	tod
	Hos 24 ho Fun eted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invesonly only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and pl	ace, and due to the	cause(s) and manner stated.
	To the within To the complete	≥	29b. Signature and title of certifier	29c. License number		Date signed (Month	
			MSil- MO	1065365		11-11-20	010
1			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	4(0), ft	WARINTA	M12074
			Mic IT A EL SIDAROUS, 17011	iring Han 1)	HIVI	// //	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 5 2010 32. Rygistrar's Signature	Print) iring Ston al			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jessie Lee Long Sims Smith November 2010 8:00 A. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 June 28, Months Days Hours 257-56-5727 76 1934 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Seat Pleasant 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Carrington Place 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. **Black** 3 Widowed 4 X Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Georgetown University Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse **Hospital**

18. Mother's Name (First, Middle, Maiden Sumame)

7503 Riverdale Road; Apt. 2032; New Carrollton, Maryland

Edwards

20c. Location - City or Town, State

Riverdale, Maryland

Thelma

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Enysician/ Medical Examiner

Physician/

Medical

10a. State

11. Marital Status

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Sonature of uneral Service

Glenda Sims (Daughter)

1 Burial 2 X Cremation 3 Removal from State

Herbert

20a. Method of Disposition

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

shov

ral", or items 23a or 28a-f shorexaminer must be notified at

"natural"

th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I

permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once.

death with

72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examine Completed by Be Medical Certificate: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

21. Schature of uneral Service is not	B. Kull		nd Address of Facility ${f R}_{f f e}$			Morticians, ton,D.C.2001
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Cerebrovasc	Do not enter the mo	de of dying, such as cardia			Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consequer					
Sequentially list conditions,	Septcemia					
if any, leading to immediate	Due to (or as a consequer		1			
Cause (Disease or iinjury that initiated events resulting in death) Last	c. End Stage Re		ase			
resulting in death) Last	ode to for as a consequer	ice oi):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No g ☐ Unknown	23c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal d 4 Pregnant at time of dea	eath 3 - Ectopic	pregnancy pecify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions co	ontributing to death but not result	ng in the underlying	cause given in Part I.		bacco use contribute to	o the cause of death? Probably 4 🗆 Unknown
				24a. Was a autop perfor 1 Yes	sy prior to med? death?	utopsy findings available completion of cause of s 2 \sum No
25. Was case referred to medical examiner?	12-2-2-1		26. Place of Death (Che			
1 🗆 fes 2 🕮 No	Hospital: 1 X Inpatient 2 ☐ EF	/Outpatient 3 □ □	OA Other: 4 \(\sum \) Nursing I	Home 5 Resid	ence 6 Other (Spec	cify)
27. Manner of Death 1	(Month, Day, Year)	b. Time of injury	28c. Injury at work? 1 ☐ Yes _2 ☐ No	28d. Describe ho	ow injury occurred	
4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factor	y, office	28f. Location (Si City or Town	treet and Number or Ru n, State)	ıral Route Number,
(Crieck 2 Medical Examil	ician: To the best of my knowled ner: On the basis of examination ar e Practioner: To the best of my kr	id/or investigation, in	my opinion, death occurred	at the time date ar	ad place, and due to the	causo(s) and manner stated
29b. Signature and itle of certifier	≥ MO		D46529		29d. Date signed (Mont. November 8	h, Day, Year)

M.D.; 7325-A Hanover Parkway; Greenbelt, Maryland 20770

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Park Crematory

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Victor Onyejiaka;

NOV 1 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a,25 of Maryland Department of Health and Mental Hygiene per me,g910,12/08/2010dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ Manth Golden E. Smith 2:591 Medical Pacility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IVISTA LATA EDIC41 WIEL harle 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 1 💹 M 2 🗆 F Months Days 07/12/1920 Director 248 22 8837 90 Greer, SC Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified or 28a-f MD Charles LaP1ata 1 ★ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6326 Grant Chapman Drive 20646 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ori Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify:Black 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumosic. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Essex Smith Mary Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Smith Lloyd/ Daughter 6326 Grant Chapman Dr., LaPlata, MD Baltimoré. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenwood Cemetery |11/22/2010 Daytona Beach, Florida 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th St., NE Washington, DC 20017 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each lipe. 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed and use as the burial-tran APPROVED BY MEDICAL EXAM that initiated events resulting in death) Last signed by the attending physician Completed by Physician/Medical ION CERTIFICA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed' (Spontaneous) 1 Yes **Physician**: 25. Was case referred to medical examiner?

1 X Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' Accident 1 🗌 Yes 2 \square No Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one 29d. Date signed (Month, Day, Year) 00008370 11-11-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SE MD, 119LAGRANGE AV. POB 1317, LA PLATA, MOZOGYC PRITCHETT 31. Date filed (Month, Day, Year) NOV 1 6 2010 32. Registra 's Signa State Registrar

			For State of Maryland / De		Mental Hygie	ne	00100		
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	. No.	38100		
	Physicia		THERESA A. SAXO)M	2. Date of Death Month 11	Day Year 10 2010	3. Time of Death		
1	Medi ∖ Examiı		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		10 2010 4c. County of Deat	3.130		
	<i></i>		SUBURBAN HOSPITAL	BETHESDA		MONTGOM			
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2XXF 7. Age (In yrs. last birthday 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birt N Y C	hplace (State or Foreign IntrNY		
	nd now at	١	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	o o o stigo					
	larylar 3a-f st iified	Director	MD PRINCE GEORGE FT. WASH			10d. Inside City Limits 11√√Yes 2 □ No			
	the Manager		10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co			
	th with ms 23 must	Funeral	3007 KINGSWAY ROAD	20744		U.S.A.			
(0	or iter		Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	· ·		
033	ırs afte ural", I Exar	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 XNo Specify:		Specify: BL	ACK		
15-(72 hou "nati ledica	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ing 16b	o. Kind of Business I	ndustry		
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nd	filed val Hyg	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		IMIN REBOUNCE		
Maryland 21215-0036	uld be I Ment narke	욘	BENJAMIN L. BRISCOE	MARIAN					
, Ma	nd 2 sho ealth an n 27 is er traur		19a. Informant's Name/Relationship (Type, Print) RONALD S. SAXON, II- Son 19b. Mai 1061	ing Address (Street and Number or Rura 1 LAKE ARBOR WAY	BOWIE, MD	or Town, State, Zip 20721	Code)		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myiniury or other traumatic event, the Medical Examiner must be notified at one.			matory or other place)		Location - City or			
Baltii	permit. F Decartm Importa eny injui	100	21. Signature of Funeral Service Licensee	2. Name and Address of Facility PI	4-2010 A	ANGLER F.	н.		
ř			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	<u> 24 - 8TH ST., N. E</u>	. WASH	DC 20002-	5236 Approximate		
~~ .	h sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CONGESTIVE HEAR		,		Interval Between Onset and Death		
1	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	I PATEORE					
		er	Sequentially list conditions, b. Due to (or as a consequence of).						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury						
	ate be executed physician and the burial-transit		resulting in death) Last C. Due to (or as a consequence of):						
200	death certificate be executed the attending physician and ed for use as the burial-transi	edical	d						
89	eath certifica attending pl	M/U	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	(on (
Box 687	death ne atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year		
		Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	Inderlying cause given in Part I	00- Bildeles				
S, T	law requires that the nas been signed by the e 2 should be detach	d by		wisserying based given in Fart.		o use contribute to t	bably 4 Unknown		
ord	w requ	plete			24a. Was an	24b. Were auto	psy findings available		
ř	Ine la cate ha page	Completed			autopsy performed? 1 Yes 2xx	? death?	mpletion of cause of		
<u>. a</u>	ector,	Be.	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		, 101			
> -	r this eral dir	e: 1	17 Inpatient 2 ER/Outpatie 27 Manner of Death 28a Date of injury 28b Time of	1	me 5 Residence		0		
00	ath. ath. rr: Afte	ficat	1 Matural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 Yes 2 No	od. Describe now inj	ury occurred			
Division of Vital Records,	after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	Route Number,		
ב כ	hours a		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	d due to the cause(s)	and manner as state	rd.		
1	to use no sparial or detections within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	igation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and place, and due to the cause	ce, and due to the ca e(s) and manner as st	use(s) and manner stated. ated.		
15	2 ₹ 2 8		29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month,	Day, Year)		
10	20	-	30. Name and address of person who completed cause of death (item 23a) (Type, it	17int) 40060117	1 0	115/2010			
R	20		ERIC PARK, M. D. 8600 OLD GEORGETOWN		ID 20814				
	State Registra		31. Date filed (Month, Day, Year) NOV 1 6 2010 Server 5. Signature						
		_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 РМ Jean Snyder November 4:24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Northampton Manor Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Dec 21, Year)947 1 □ M 2 🛣 F 214-48-4100 Maryland **Director** 62 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 X Yes 2 □ No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 21702 448 Heather Ridge Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". Specify: White Completed 3 - Widowed 4 X Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot Donald Morgan Mary Summers 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10687 Salen Avenue, Thurmont, Maryland 21788 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mr. Greg Snyder, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Mt Olivet Cemetery Dec 3, 2010 Frederick, Maryland 4 Donation 5 Other (Specify) of Funeral Service Licer 21. Si a atu Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701 MOO706 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ponset and Death Immediate Cause (Final disease or condition BALLE SYNONOME Physician/ a GULLIAN Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last inding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live and Live Birth 2 Live Birt in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one 29b. Signa

MAYERN

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DOOLLL23

196 TT DLUG FREIDNUK, MD 21702

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month Year Imes 2138 PM tongr owava 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ennet Nuvsinc Garrer 194 . Age (In y s. 8. Date of Birth Month, Day, Year March 23, 1924 **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Days Hours Min. 86 Director Mapletown, PA 181-14-7318 Yrs Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Oakland Garrett 1 U Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6577 George Washington Highway USA 21550 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. 1943–45 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 - Widowed 4 X Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmais. Elementary/Seconday (0-12) College (1-4 or 5+) Plasterer/Mason Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Ray Stoner LueHaze1 Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freddie Stoner 6577 George Washington Highway, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wolf's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Dec.1, 2010 Dilliner, PA 15327 4 Donation 5 Other (Specify) of Funeral Se 🍱 Licensee 22. Name and Address of Facility Herod Funeral Home, 501 Morgantown St., Point Marion, PA 1547 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions land, leading to amediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence) of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day should be detached significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗆 Yes 2 🗆 No 3 🗔 Probably 4 🗗 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

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To the Funeral C filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my office at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar

	1	_ State	-	partment of Health and Merertificate of Death	Reg. No.2010 38103				
		Registrar 1. Decedent's Name (First, Middle, Last)		2.	. Date of Death 3. Time of Death				
Physicia	ın/	_			Month Day Near by Year November 5, 2010 0920M				
Medic Examin		Kevin Sprole 4a. Facility Name (if not institution, give street and r		4b. City, Town, or Location of Death	4c. County of Death				
L-Xalliii		1204 Palmer Rd. #12		Fort Washingto					
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)				
Director		215-11-4514	39 Yrs.		Sept. 14, 1971 MS				
show	1. F	10a. State 10b. County	10c. City, Town or L	ocation	10d. Inside City Limits				
within 12 foots and count min in the many man gives. er than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho it the Medical Examiner must be notified at	ect	MD PG	Нуа	ttsville	1 🔀 Yes 2 □ No				
or 2		10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?				
is 236 nust k	Funeral Director	4809 Trenton Road		20784	United States				
r item		Armed	ecedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.				
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f Heal item other		20a. Method of Disposition	20b. Place of Disp	9 Trenton Road ttsville, MD. 20 position (Name of position (Name of position (Name of position)) Dat	20c. Location - City or Town, State				
ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State Cedar H	Fill Cemetery 11/	11/15/10 Suitland, MD.				
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Hod	ges & Edwards F.H.				
Departi Import any inj			vaids 3	2010 Silver Hill	Rd., Suitland, MD. 20746				
hysician/ Medical		shick or heart failure. List only one cause of Immediate Cause (Final disease or condition	hat caused the death. Do not en n each line. ~ Ter, "US C	nter the mode of dying, such as cardiac or re					
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DHMH 17 Rev 7/2009

Randolph R Sm		1- For State Registrar	State of Maryla		artment of ertificate of		Mental Hy		Reg. No.	20 i	0	38101
Physici Medical Exami	an/	Decedent's Name (First, Michael Control of the						Date of Dea Month	ath Day	Year	3	3. Time of Death 1202 hrs
٠		4a. Facility Name (if not institut		<u>l</u> umber)		tb. City, Town, or L	ocation of Death	Novembe	40	c. County of E		
Euroral		Southern Maryland I 5. Social Security Number	Hospital 6. Sex	7. Age (In yrs.	(net hirthday)	Clinton If Under 1 Year	If Under 24Hrs.	To Date of Bi		Prince Geo	•	Splace (State or Foreign
Funeral Director		579-62-0523	1 XM 2 F	/. Age (iii yis.	63 Yrs.	Months Days	Hours Min.				Count	place (State or Foreign \mathfrak{sh}_{ullet} , DC
y		Usual Residence of Decedent		L				Plat Cit		<u>' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' </u>		
ne Maryland or 28a-f show any fied at once.		10a. State 10b. Count			y, Town or Location						- 1	10d. Inside City Limits 1 Yes 2 No
Aarylan 28a-f sl	ecto	MD 10e. Street and Number	PG	5	uitlan	Ol 10f. Zip Code		1	10g. Cit	tizen of What		
th the A 23a or notifier	힐	3107 Lassie				207				ited S		
2 hours after death with th "natural", or items 23a Examiner must be noti	Funeral Director	11. Marital Status 1 Never Married 2	Married Armed F			s Decedent of Hispa es, specify Cuban, I			0-	14. Race - A White, e		n Indian, Black,
after de	by Fu	3 Widowed 4 XD	1 X Yes Divorced If Yes, Give Yea or Dates:	2 No ar	1	Yes 2 X No	specify:			Specify: B	ו ם כי	r
hours "natur	ted t	15. Decedent's Education (Sp Elementary/Secondary (0-12			16a. Decedent during mo	t's Usual Occupationst of working life. I	n (Give kind of w	ork done ed)	16b. l	Kind of Busin	ess/Indu	ustry
5-0036 ed within 72 tygiene. other than '	Completed	12	t) Conege (1-4 01 5+)		Engine	or			Pri	ivat	+0
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	S	17. Father's Name (First, Middl				18	3. Mother's Name			Surname)	<u>. v a .</u>	<u>Le</u>
212'	To Be	Randolph 19a. Informant's Name/Relation	Smith nship (Type, Print)		19b. Mailing	Address (Street a	Geneva and Number or R	Rural Route Nur	sbr mber, C	COOKS	State, Z	(in Code)
MD rd 2 sho Uth and m 27 is aumati		Randolph Sm		er	3107 Suit	Lassie land, Mi tion (Name of ceme	Avenue	<u> </u>				
		20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal fr	com State	Place of Disposit crematory or oth	tion (Name of ceme er place)	etery,	Date	20c.	Location - Cit	y or To	wn, State
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other 3	Specify:	Іма	. Nati	onal Cer ame and Address o	metery	11/17	/10	Lau	ıre.	1,MD
Ba Perm Degra inju	- 1	Janus	Edwar	de	39	10 Silve	er Hill	l Rd.,	Su	uitlar	; F.	.н. MD.20746
Physician		23a/Part I. Enter the disease, of failure. List only one caus	se on each line.		n. Do not enter the	e mode of dying, su	ich as cardiac or	respiratory arr	est, sho	ock, or heart	1	Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final diseas or condition resulting in death)		rotic Cardiov		ease					+	Death
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	Examine	if any, leading to immediate rause. Fitter Underlying Cause (Disease or injury that initiated	C	a consequence o								
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ਲ ਲੋਫ	edical	UNPENDED	AMENDED			<u></u>					\top	·
3760, ficate be g physicist the buri	1/Mec	IF FEMALE: 23b. Was decedent pregnant in	tho	outcome of preg			7		230	d. Date of deli		
Box 6876. death certificate the attending phy death onse as the b	Physician/M	past 12 months?	4 Pregn	nant at time of de	nath	aldeath 3 er (Specify)	Ectopic pregnar	ıcy		Month	Day	/ Year
Hed the	Phys	Part II. Other significant cond	nknown 9 Unkno		resulting in the ur	nderlying cause give	en in Part I	23e. Did to	phacco	use contribut	e to the	cause of death?
, P.O. res that th	ρ	Chronic alcohol abu				Identifing sec 5	DIT 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					ly 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed							24a. Was a autop	sy			osy findings available apletion of cause of
ial Reccinan: The lar	Som								rmed?	deatl	h? Yes	2 No
Vital Pysician:	8	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatient	-	f Death (Check or ther: ₄ Nursing		Pacido	ence 6 0	VAL NO.	
n of V ding Phys After thi funeral di	라	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of Inj			28d. Describe h			ther:	
ision Attendir r death. rector: A	atio		nding restigation				s 2 No					
Divis tal or A rs after al Direct	Certification:	. dete	uld not be termined (Specify)		ome, farm, street	, factory, office buil	ding, etc.	28f. Location (S or Town, S		nd Number or	Rural I	Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier (Check only 1 Certifying F	Physician: To the bes	st of my knowled								
To the Hos within 24 h To the Fur completely	ge	one) 2 Medical Ex	aminer: On the basis of and manner st	of examination a tated.	ınd/or investigatio			the time, date				
	2	29b. Signature and title of certifi	ier a	11	1	29c. License n				Date signed (rember 7, 2		Day, Year)
2 2	-	30. Name and address of person	on who completed caus	se of death (Item	123a)							
P 3		· ·	Assistant Medica			Street, Baltim	ore, MD 212	.01				
Sta Regist	ate rar	31 Date filed (Month, Day Year, NOV 1 7 2010	Dennis Re	egistraf's Signatu	tille							

			Ctata	epartment of Health and Mental Hygiene Pertificate of Death Reg. No. 2 1 3 8 1 0 5
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Medic	cal	Nancy Patricia Swann	11 ^{Month} -2010 ^{ay} Year 7:27 p M
	Examir	ner	4a. Facility Name (if not institution, give street and number) St. Mary's Hospital	4b. City, Town, or Location of Death Leonardtown 4c. County of Death St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign
	Director		214-32-9613 1 □ M 2X F 76 Yrs	Months Llavs Hours Min Month Day Voor
	ind ihow at	۱	Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or	Location 10d. Inside City Limits
	//anyla //Ba-fs tified	Director	Maryland St. Mary's Lexing	ton Park
	a or 2 be no		10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th witl ms 23 must	Funeral	21716 Cabot Place	20653 USA
(0	or iter	by Fu	Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
036	rs afte Iral", Exan	ed b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify: Specify: White
15-0	2 hou "natu edical	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working 16b. Kind of Business Industry
121	ithin 7 ene. • than he M	Som		DO NOT use retired)
d 2	iled w I Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)	Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname)
ylar	d be f Menta arked	은	William Gardiner	Agnes Cooksey
Jan	shoul		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, N	and 2 s Health tem 27		20 1/1/1 1 4/1/1	716 Cabot Place, Lexington Park, MD 20653
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	1 🛣 Burial 2 □ Cremation 3 □ Removal from State	position (Name of Date 20c. Location - City or Town, State
altir	mit. P partme sortar injur.			Memorial 11/19/2010 Waldorf, MD
ä	permi Depa Impo any ir	()	Danielle Ward	22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 three Notch Rd., Charlotte Hall, MD 20622
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
die	Ph_sician/ ► Medical	4	Immediate Cause (Final disease or condition resulting in death) a. Metastatic	Lung (ancer Conset and Death
and the	Examiner		Due to (or as a consequence of):	
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	tuted and ransit	Examiner	Cause (Disease or iinjury that initiated events	
	ate be executed hysician and the burial-transit	at E	resulting in death) Last Due to (or as a consequence of):	
760	cate b physic the b	edical	d	
687	v requires that the death certificar been signed by the attending phe should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Schools programs: 23d. Date of delivery
Вох	death	sicia	1 103 22 110	☐ Ectopic pregnancy ☐ Other (specify) Month Day Year
o.	at the		g Unknown Part II. Other significant conditions contributing to death but not resulting in the	
ς, σ	signer signer	d b	The second second conditions contained to death but not resulting in the	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ord	/ requ	lete		24a. Was an 24b. Were autopsy findings available
Division of Vital Records,	sician: The law i certificate has b irector, page 2 s	Completed		autopsy prior to completion of cause of
<u>.</u>	sian: I ertifica ctor, p		25. Was case referred to medical examiner?	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)
Ξ ϳ	hysic this ce al dire	유	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Teories to Elicitic (Openin)
O	ding F h. After funer	Certificate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	work?
015	Atten r deat sctor: by the	Ĭ	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number,
≥ ;	tal or rs afte al Dire		building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Check Z I Medical Examiner: On the basis of examination and/or inve	n occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
1	o the		only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	- 3 F 8) all	29d. License number 29d. Date signed (Month, Day, Year) 1 \ / 15 / 2010
)	ا	1	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)
)bu			Dr. Gurdeep S. Chhabra, 23415 Three	Notch Rd., California, MD 20619
	State Registra	- 1	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	
	i logistra		NOV 1 6 2010 Duna A.	racke

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iease	Type or F	rint in B	iack i	ındelible	ink.	Ensure	All C	opies	Are I	_egib
	State of	Maryland	/ Dep	oartment o	of Hea	alth and	Ment	tal Hygi	ene -	UI

		1 - State Registrar	Cer	tificate of L	Death		Reg. N	No.			
Discontin	. ,	1. Decedent's Name (First, Middle, Last)				2. Date of D	Death 3. Time of Death				
Physic Med		Charlotte Williamson Simon				Novemb	er 1	3, 20	Year 10	12:30P M	
Exam		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of D		- $ -$	c. County o		112.501	
		311 Shagbark Drive #1		Westmin	nster		lo	arrol	1		
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 🖫 77	birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B Min. (Month, I May 12	irth		9. Birthp	place (State or Foreign try) vland	
d Jow	٦.	Usual Residence of Decedent 10a. State 10b. County 10c. City 1	-						- 1		
ırylan a-f st	당	7							1	0d. Inside City Limits	
r 28g	Director	Maryland Carroll 10e. Street and Number	west	minster			_		\perp	1 XYes 2 No	
ith th				10f. Zip Code				Citizen of Wh		•	
ath w	Funeral	311 Shagbark Drive #1 11. Marital Status 12. Was Decedent Ever in U.S.	13 1/		21157	2 (Chaoife Voo as No		nited			
6 ser de or its mine	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	li II	Yes, specify Cuba	in, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	,-	14. Race - Black,	- America , White, e		
OO3	ed		1	☐ Yes 2🔀 No	Specify:			Specify:	Whi	te	
5-C	plet	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa		working	16b.	Kind of Busi			
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho,; the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)	rung most or	Working					
d 2 Hygir Sther	Be	12 17. Father's Name (First, Middle, Last)	Sec	retary	40.14.11.1				onst:	ruction	
Iryland 21215-0036 Juid be filed within 72 hours after death with the Maryland of Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.		Reese Williamson			Berth	Name (First, Middle na Wdzie					
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number o	r Rural Route Numb	er, City c	or Town, Sta	te, Zip C	ode)	
e, N and 2 Health tem 27	1			Landcaste	er Cour		_			21797	
Baltimore, permit. Page 1 and Department of Hes Important: If item any injury or othe once,		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cem	etery, crem	atory or other place	· •	Date	1	Location - C		,	
alti mit. P partm portar injur			Journ 22	ey Cremat	cory 11	1/16/2010	Wo	<u>odbine</u>	<u>≥, M</u>	aryland	
		Quanta Rahomas MO09	57 Be	ing Home verly L.	Cremat Heckro	tion Servi otte, P.A	ice Cl	P.O. I arksv	3ox ′ ille	784 , MD 21029	
	П	23a. Part. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on ach line.	o not ente	r the mode of dying	g, such as card	diac or respiratory a	rrest,		- 1	Approximate Interval Between	
Physician/ Medical		Immediate Cause (Final disease or condition	204	C Car	cer					Onset and Death	
Examiner		resulting in death) Due til (or as a consequence)	ce of):								
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th cer ttendi		23b. Was decedent pregnant in the past 12 mopths? 23c. If yes, outcome of pregnancy	eath 3 🗌	Ectopic pregnancy	у		-	23d. Date		ry	
box	Physician	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown	:h 5 □	Other (specify)				Month	1 [Day Year	
that the detac	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did 1	obacco	use contribu	ute to the	e cause of death?	
uld be										ably 4 🗌 Unknown	
ecords, e law requires e has been sig	Completed					24a. Was		24b. We	re autops	sy findings available	
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ysician: s certifica director,	Be	25. Was case referred to medical examiner?		26. Pla	ice of Death (C	Check only one)	21 N	01 1	Yes 2	: 1	
hysic his ce	욛	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/	'Outpatient	3 DOA Other	r: 4 🗆 Nursin	g Home 5 Resi	dence (6 🗌 Other (S	Specify)		
ing Pl	ate:	27. Manner of Death 28a. Date of injury 1 Natural 5 Pending (Month, Day, Year) 28k.	o. Time of injury	28c. Injury work?	•	28d. Describe I	now injur	y occurred			
VISION or Attendir fler death. irector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No				_		
al or A safter Direct of in by		4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (City or Tov	Street an vn, State	d Number o	r Rural R	loute Number,	
DIVISION OF VITAIL RECORDS, P.O. BOX 68 /60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and	e, death oc	cured at the time,	date and place	e, and due to the ca	use(s) ar	nd manner a	s stated		
o the lithin 2 o the Formplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knot 29b. Signature and title of certifier	owledge, de	ath occurred at the	time, date and	place, and due to th	e cause(s) and manne	er as state	red.	
F3Fö		· hand		29c. License	7 7 1		29d. Da	ite signed (M	io n th, Da	ıy, Year)	
		30. Name and address of person who completed cause of death (Item 23a	a) (Type Pri	nt)	· C ()	<i>√</i> 3	11	17/13)		
5		Thomas J. Vento, M.D. 114 Busine			ive Re	eisterstov	m, i	Marvla	and :	21136	
Sta Registra		31. Date filed (Month, Day, Year) NOV 16 2010 32. Registrar's Signature		uke							
		7-2-1	- Marida as								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gertrude Stahl Medical 5:15 PM November 2010 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Folhrne Boonsboro Washington If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Pay, Year)
Dec. 16, 1910 **Funeral** 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Months Director 99 Pennsylvania 161-26-7138 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11812 Bradford Dr. 21740 U.S.A. 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Flower Grader Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Asa W. Roadarmel Hazel Keller Roadarmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Getz-Son in law 11812 Bradford Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State cemetery, crematory or other place, any injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11-22-2010 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Dementia disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner pertension Secue tially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due failure Chronic renal Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be eral Director: After this certificate has been signed by the attending I filled in by the funeral director, page 2 should be detached for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 N 2 L No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No ျ Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide 1 🗌 Yes 2 🗆 No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3H-2

State

DHMH 17 Rev 7/2009

31. Date filed (Month, Day Registrar

29b. Signature and title of certifier

Kate M. Smith

Kate yn Smuth CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

R128088

1126 Opal Court, Hagerstown, Manyland

29d. Date signed (Month, Day, Year)

November 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Margaret Lucille SNYDER November 2010 2:03 a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 268 South Potomac Street Hagerstown Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 M 2 K F Months Country) Unknown Director Yrs 230-46-7962 Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 X Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 268 South Potomac Street 21740 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: marked other than "natural", 3 🕅 Widowed 4 🗆 Divorced Specify: Completed White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. n Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lester Brathwaite unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 1 and 2 s of Health item 27 i Rose Forsythe - Daughter 987 Bingaman Road, Orrtanna, Pa. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H 20c. Location - City or Town, State cemetery, crematory or other place) Important: If i 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory 11/21/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ MYOCANDUAL NEAKCTION 0-15mm **Medical** resulting in death) Due to (or as a consequence of) Examiner CUNGESTIVE Y EARS Chemi Sequentially list conditions Se quentially list and if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit CARDIOMYORATURA WITH EJELFION PROKETION LESS THAN YUARI. Due to (or as a consequence of): attending physician Physician/Medical PALLUNE tiony. MHEL use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstitutive lunc Disense Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DEBILITY. 24a. Was an page 2 performed? Yes 2 No this certificate HOSPILE CAME 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 PNo 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred ivatural Accident Suici 1 Natural 5 Pending s after death 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

SH-2

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

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RADIR

GIMZAUN

31. Date filed (Month)

MD

1190

32. Cegistrar's Signature

Mr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Registrar
DHMH 17 Rev 7/2009

AENIA

046501

ROMD

HAGENITOWN

Nov: 19

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#17perFH, G910, 127872010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 12, 2010 Physician/ 02:05 A Norma Skipworth Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton er 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Aug 10, 1930 Great Britain 80 Director 579 48 5295 Usual Residence of Decedent show 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland Director 1 Yes 2 XXNo Upper Marlboro Prince George's Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12202 Westview Drive 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11, Marital Status Black, White, etc. Completed by 1 Never Married 2 MMarried 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 XX Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Data Processing Be 17. Father's Name (First, Middle, Last) Tyldesley 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Alice Barrett Tuldesley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12202 Westview Drive, Upper Marlboro, MD 20772 Douglas D. Skipworth (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Nov 18, 2010 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Line Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYDCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) 4 Pregnant a page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBRO VASCUL AR ACCID FONT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mar ner Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injurv +atural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of MD D0064986 11/13/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MB5 ONWUKA 7503 SURRATTI ROAD CLINTON 32 Registrar's Signatur 31. Date filed (Month, Day State NOV 1 o 2010 Registrar

Registrar

State

912 Seton Drive, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregg C. Donaldson, M.D., 912 Seto

#82. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 15 2010

	•	1 - State Registrar			Cer	tificate of l	Death		Reg. No.	010	38111
Division		1. Decedent's Name (First, Middle	le, Last)					2. Date of D	eath Day	Year	3. Time of Death
Physici /Medic		Charles	Evers		Sm	ith, Jr.		Novem		13, 2010	6:42 P M
Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	Location of Deat	h	4c.	County of Deat	
<i>y</i>		Devlin Manor					erland			Allegar	
Funeral		5. Social Security Number	6. Sex 7. A	ge <i>(In yrs. last i</i> 79	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		irth Da <i>y, Y</i> ea <i>r)</i>	9. Birt	thplace <i>(State or Foreign</i> buntry) st Virginia
Director		220-34-1535 Usual Residence of Decedent	X	19	115.			02/22	/1931	l Wes	st Virginia
and		10a. State 10b. County	,	10c. City, To	wn or Loc	ation					10d. Inside City Limits
Maryl f sho	ō	MD Al	legany		С	umberlan	d				1 □Yes 2 💢 No
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with Sa or	Funeral Director	12805 Growder	nvale Drive	NE				USA	,		
ns 2:	era	11. Marital Status	12. Was Decedent		13. V	Vas Decedent of H	21502 ispanic Origin? (S	Specify Yes or N	10-	14. Race - Ame	erican Indian,
fler of riter	ᆵ	1 ☐ Never Married 2 🗓 Mar	ried Armed Forces'	? № 1951.	_ If	Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Black, White	e, etc.
filed within 72 hours after death with the Maryland Hygiene. Hygiene. The "netural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	I If Yes Give	1955	1	□Yes 2∏XNo	Specify:			Specify:	White
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Departments of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Maria K. Smith		1:		g Address (Street: 5 Growde			-		Zip Code) d, MD 21502
ges 1 groff He If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other plac	re)	Date	20c. Lo	cation - City or	Town, State
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permit Depar Impor any in		21. Signature of Funeral Service	Licensee			Name and Addres 04 Decatu			-		Home, P.A. 21502
		23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause	d the death. D	o not ente	er the mode of dyin	ıg, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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Examiner			h								(
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ath c	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pregnanc	y		:	23d. Date of de Month	livery Day Year
Attending Physician: The law requires that the death death. ector: After this certificate has been signed by the atter by the funeral director, page 2 should be detached for u	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death	1 5∟	Other (specify)					,
that ti		Part II. Other significant conditi	ons contributing to death	out not resulting	in the un	deriving cause give	en in Part I.	23e. Did	tobacco u	ise contribute to	o the cause of death?
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has has	ш							24a. Wa aut	s an opsy fo rmę d?	prior to death?	utopsy findings available completion of cause of
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siciar certii recto	Be	25. Was case referred to medica examiner?	Hoenital:			Oth	26. Place of De				
Phys rthis raldi	٦.	1 Yes 2 No 27. Manner of Death	1 ∐ Inpat 28a. Date of Inj	ient 2 ER/	Outpatient	3 DOA	4 LA Nursing I	dome 5 ☐ Res			ecify)
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Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	not be 280 Place of In	jury - At home,	farm, stre	et, factory, office		28f. Location	(Street an	d Number or R	ural Route Number,
after after Dire	Certification: To	4 ☐ Homicide determ	building, e	tc. (Specify)				City or To	own, State)	
spita nours neral / fille		29a. Certifier 1 X Certifyi	ng Physician: To the bes	t of my knowled	lge, death	occurred at the tir	me, date and plac	e, and due to the	e cause(s) and manner a	s stated.
te Ho 24 h te Fu	Medical	(Check only 2☐ Medical one)	Examiner: On the basis and manner s	of examination tated.	and/or inv	restigation, in my o	pinion, death occ	urred at the time	e, date and	d place, and due	e to the cause(s)
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	ME	29b. Signature and title of certifie	er 0			29c. Licens				te signed (Mont	
			2 the			D332	80		I	Novembe	r 15, 2010
14		30. Name and address of person	who completed cause of	death (Item 23a	a) (Type, F	Print)					
nas		Sunil K.	Gupta, M.D.,	625 1	Kent	Avenue,	Cumberla	ind, MD	215	02	
01		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		¢.					
Sta Registr		31. Date filed (Month, Pay, Year)	n /n	A Pos	Carried House						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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	Examin		4a. Facility Name (if not institution WMHS - Region	4 4 1	1 Cente	R	4b. City, Town, o	r Location of I	Death Ad	4c. Co	unty of Death	ny	
	Funeral Director		5. Social Security Number 220–16–6504	6. Sex 7. A	ge (In yrs. last bii 32	rthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Min. (Month, L FEB. 2	irth Da <i>y, Year)</i> 7, 1 928	Cou	hplace (State or F intry) YLAND	-oreign
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36	ould be filed within 72 hours after death with the Maryland do Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural".	d by Funeral	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ried 1 Yes 2 1	Ev1945-4 No 1950-5	7 13. V		lispanic Origin an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	D- 14.	Race - Amer Black, White	, etc.	
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Baltimore,	Page nent c ant: If Iry or		1 X Burial 2 Cremation 4 Donation 5 Other (S		e cemet	ery, cren ROCK	sition (Name of natory or other place Y GAP CE	M DE	Date C 2, 2010	FLIN	on - City or ⁻ ISTONE	, MD	
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	ath certificate be executed attending physician and for use as the burial-transit	Examiner	Sous itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	a consequence	, ,							
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. Box 68760	Attending Physician: The law requires that the death certificate be at death. ar death. ar death. by the funeral director, page 2 should be detached for use as the but.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal dea at time of death		Ectopic pregnand Other (specify)	су		23d	Date of deli Month	very Day Yea	ar
ls, P.O.	uires that t n signed by ild be deta	ρ	Part II. Other significant condition	conscionation of the contributing to death		_	nderlying cause gir			/		the cause of deat	
Records,	ilcian: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed							per	s an 24 opsy formed? 3 2 No	prior to c death?	opsy findings ava ompletion of caus	ailable se of
Vita	hysician: nis certific I director,	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	tient 2 LER/O	utpatien	_ loth	er _	(Check only one) ing Home 5 \square Res	sidence 6 🗆	Other (Specia	(y)	
Division of	ending P sath. or: After ti he funera	Certificate:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	gation		Time of injury	28c. Injur work M 1 □			how injury occ	curred		
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place of In	jury - At home, f tc. (S <i>pecify)</i>	arm, stre	eet, factory, office			(Street and Nu own, State)	mber or Rura	al Route Number,	
	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination and/	or invest	igation, in my opinio	on, death occu	irred at the time, date	and place, and	due to the c	ause(s) and manne	er stated.
	viti To t		29b. Signature and title of certifier	s Ella	well.	nh	29c. Licenso	7,~,	35	29d. Date sig	_	/	
			30 Name and address of person of homes	= Chain	111 1	(Type, P	917S	elan .	D. 111	Mber	land	(111)	
	Sta Registra		31. Date filed (Month Pay, Year)	2010 32/Pegist	rar's Signatu	190	all		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				aryland / Depa			nd Mental Hy	giene	
			State Registrar	Cen	tificate of L	Death		Reg. No.	38113
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of De Month		3. Time of Death
-46	Medic		Melvina Lorraine Somm	er			Nov.	26, 2010	10:02A M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o		Death	4c. County of D	
James	<u> </u>		Stella Maris 5. Social Security Number 6. Sex 7. Age	and the state of t	Timor	11UM If Under 24	Tura La Dia della		imore
0	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2X F	e (In yrs. last birthday) 64 Yrs.	Months Days				Birthplace (State or Foreign Country) MD
1.3			Usual Residence of Decedent	04			pec. 1.	3, 1943	MD
	and shov	for	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
	Mary 28a-f stifie	Director	PA York	Sh	rewsbur	CV			1 🙀 Yes 2 □ No
	a or S	E D	10e. Street and Number		10f. Zip Code			10g. Citizen of What	
m.	n with	Funeral	11 Courtyards Drive			17361		U.S.	.A.
ਰ	deatl item ner.n		11. Marital Status 12. Was Decedent E Armed Forces?	lf .	vas Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian,
02	after Il", or xami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Yes 3 ☐ Widowed 4 ※ Divorced Year or Dates	No 1	☐ Yes 2 🗷 No	Specify:		Specify:	White
10:02 215-0036	nours atura cal E	Completed	Year or Dates. 15. Decedent's Education	16a Deced	ent's Usual Occup	ation		16b. Kind of Busine	
75	1721 an "n Medi	mp	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	(Give k	ind of work done of NOT use retired)	during most o	f working		
10	withii giene er th , the		Elementary/decorday (U=12)	House	ekeepin	g Sup	ervisor	Manufac	turing
2010 nd 21	filed al Hy d oth) Be	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle,	Maiden Surname)	
ya Ya	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ပ	William A. Bosley			Alma	Marie B	osley	
26 Aary	shou and ris rr		19a. Informant's Name/Relationship (Type, Print)		- :			r, City or Town, State,	•
ER,	and 2 lealth em 2; ther t		Thelma Billet/Sister 20a. Method of Disposition					and, MD	
E S	Page 1 anent of Hant of Hant of Hant of Hurk or of Ury or of		1 XBurial 2 Cremation 3 Removal from State	20b. Place of Dispos	atory or other place		ec. Date 1,	20c. Location - City	
NOVEMBER 26, 2010 Baltimore, Maryland 21	it. Pa urtmei urtant njury		4 Donation 5 Other (Specify)	Wiseburg			2010	White Ha	The same of the sa
N Ba	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	22.	Name and Address	cond	J,J. Harte St New	nstein Mo Freedom	rtuary, Inc. , PA 17349
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not enter					Approximate
	Physician	100 - 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death
	Medical		disease or condition resulting in death) LUNG CA Due to (or as a	INCEK consequence of):					
	Examiner	L	Sequentially list conditions, b.						
	7 =	ine	if any, leading to immediate Due to (or as a cause. Enter Underlying	consequence of):					
	and trans	Examiner	Cause (uisease or imjury that initiated events resulting in death) Last Due to (or as a	consequence of):					1
_	cate be executed physician and the burial-transit	alE	resulting in death) Last	consequence on.					
<u></u> 2	cate the physis the I	edical	d						
200	certific nding puse as	<u>N</u>	IF FEMALE: 23c. If yes, outcome c	of pregnancy				23d. Date of	delivery
Box	eath a atte	icia	in the past 12 months?		Ectopic pregnant Other (specify)	У		Month	Day Year
	The law requires that the death ate has been signed by the atte page 2 should be detached for	Completed by Physician/M	9 Unknown						
MELVINA SOMMER Vital Records, P.O.	s that gned l	by F	Part II. Other significant conditions contributing to death but	it not resulting in the un	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
So.	quire en si ould t	ted					_ 1 -	Yes 2 No 3	Probably 4 X Unknown
NA	law re	nple					24a. Was autor	osy prior t	autopsy findings available to completion of cause of
Re	The page	Cou					perfo	rmed? death	? ⁄es 2 □ No
E E	ician sertifi ector	m	25. Was case referred to medical examiner? Hospital:				(Check only one)		
	Phys this ral dir	2	1 ☐ Yes 2 💹 No 1 ☐ Inpatie 27. Manner of Death 28a. Date of injury	ent 2 ER/Outpatient v 28b. Time of		4 ∟ Nurs			ecify) HOSPICE
n 0	ding th. After fune	Certificate:	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	28c, Injury work M 1 🗌	yaı :? Yes 2. ∏ N	i	ow injury occurred	
Sio	Atten r dea ector: by the	rtifi	3 Suicide 6 Could not be 28e. Place of Injur	ry - At home, farm, stree	the state of the state of		_	Street and Number or I	Rural Route Number,
Division of	s afte		building, etc.	(Specify)			City or Tow	n, State)	
	lospit t hour uners ed fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of ex-	ny knowledge, death or	ccured at the time	, date and pla	ce, and due to the car	use(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Me	only one) 3 X Certifying Nurse Practioner: To the b	pest of my knowledge, de	eath occurred at the	e time, date ar	nd place, and due to the	e cause(s) and manner	as stated.
	5 V V I		29b. Signature and title of certifier	101	29c. License	i number	(1)	29d. Date signed (Mo.	nth, Day, Year)
	•		30, Name and address of person who completed cause of de	onth (Hom 22a) Time T	int)	41	414	11/20	110
				DULANEY VA	,	ттмо	NIUM, MD 2	1003	
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	HATEL KD.	I IMO	MIONS FID Z	1073	
	Registra		DEC 0 6 2010 Server 1.	garre					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOV. 26, 2010 **Physician** GRACE ANNE SUTHERLAND 11:00P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES WALDORF 1006 DARTMOUTH ROAD If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 8 – 4 – 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral WASH., D.C. Months Days Hours Min. 1 □ M 2 □ 578-02-4396 47 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show od 2 should be filled within 72 hours after death with the Maryla th and Mental Hyglene. The marked disher than "natural", or Items 23a or 28a-f shoo ar is manualle event, It. M. vice Examiner must be notified at traumatic event, It. M. vice Examiner must be notified at 1 □Yes 2X No WALDORF MD. CHARLES Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1006 DARTMOUTH ROAD 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation filed within 72 h I Hygiene. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) INFORMATION RESOURCE SPEC DEPT.OF ENERGY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PHILIP MARCIAN TAYLOR GENEVIEVE MARIE BOOTH thand 2 should by Health and Ment tem 27 is marked ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 DARTMOUTH RD. EDDIE J.SUTHERLAND-SPOUSE WALDORF, MD. 20602 permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEM GARDENS 12-1-2010WALDORF, MD. M00479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. <u>LA PLATA, MARYLAND 20646</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ran disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 01 Sequentially list conditions, it any leading to find edite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dua to (bries a nonsequence of) Examine Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Year Month signed by the aid be detached for 5 Other (specify) ☐Yes 2 🖼 No o 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown cate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1∐Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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DHMH 17 Rev 1/2001

Ridac

32. Registrar's Signature

Road Westminster

MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOUD

TARIQ

State Registrar 31. Date filed (Month, Day, Year)

of Death			2	Time	6	Dool
Reg. Nø.	0	0	3	8	Of the last	
Hygiene						

Reg.	Nø.	0	-	0	3	8		6
te of Death onth	Day			Year	3.	Time	e of Deat	th

17, 2010 Nov.

12:25A M

4b. City, Town, or Location of Death Oakland

4c. County of Death Garrett

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Months

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 12/10/1932

Maryland

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Oakland

10f. Zip Code 10g. Citizen of What Country?

21550 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

U.S.A. 14. Race - American Indian, Black, White, etc.

White

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Specify:

Home

Homemaker

18. Mother's Name (First, Middle, Maiden Surname)

Nellie

Arnold

V

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ob. Place of Disposition (Name of Garnete Promato & Other blage) Gardens

5086 Underwood RD., Oakland, MD 21550 20c. Location - City or Town, State

11/20/10 | Oakland, Maryland

22. Name and Address of Facility Newman Funeral Homes P.A. 203 S. Second St., Oakland, MD 21550

the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 □Ectopic pregnancy

23d. Date of delivery Month

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4□Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

1 Tes

1∐ Yes

26. Place of Death Check onl one

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown 24a. Was an performed'

2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

Other: 4 Harsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Destricting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Johnson

311 N. Fourth St., Oakland, MD 21550

31. Date filed (Month, Day, Year) NOV 1 8 2010 32. Registrar's Signature

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral I

ORIGINAL

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Completed

Be

Certification: To

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ΰ, Physician/ 2010 8:30 AM Marv Walker Shirlev November Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Frederick Edenton Retirement Community Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 28, Year 926 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 X F Months Virginia 577-38-5638 84 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21703 5800 Genesis Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirange. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Geological Survey Computer Specialist 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Catherine Shotrof Edgar John Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4902 Shadywood Drive, Jefferson, MD 21755 Jon Walker / Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Crematory 1 Durial 2 Cremation 3 Removal from State 2010 Frederick, Maryland 4 Donation Other (Specify) 21. Signature Turn Sume Licensee RESCHERVER FUHETAL Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Alzheimer's Dementia Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last physician are the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 🔀 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed' Yes 2 XX No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? To the Hospital or control within 24 hours after death.

To the Funeral Director: After this ce Other: 4 🗵 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 🔀 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending 1 Tes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 12, 2010 R050603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taney Avenue, Frederick, MD 21702 CRNP 1475 Kathryn Traepe, 31. Date filed (Month, Day, Year) 32. Registar's Signature State Morara NOV Registrar

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		For State		State	e or ivia	aryıan		artmei <i>tificat</i>			na i	Mental Hy		20	n	38118
		Registrar 1. Decedent's Name	e (First, Middl	e, Last)			Cer	incai	e oi L	Jean		2. Date of D	Reg. N	l¢ ∪		3. Time of Death
Physici Medi		Mary	Estel	la St	ring	er						Month Nov.	9,	^{ay} 201	Year 0	11:04 a ^M
Exami		4a. Facility Name (if			number)					r Location of [4	c. County		
		519 Orc 5. Social Security N		Way 6. Sex	7 / 20	An un la	ast birthday)		ilv∈ er 1 Year	er Spr		ng I 8. Date of B	- L	Mon		mery
Funeral Director		577-26-	6727	1 M 2 D	Xŧ /. Age	8 7	Yrs.	Months			Min.	May 2				pplace (State or Foreign ntry) M D
nd show at	5	Usual Residence of 10a. State	10b. County			10c. City	y, Town or Lo	cation								10d. Inside City Limits
Aaryla 8a-f s tified	Director	FL	Pa	lm Bead	c h		J	Jupi	ter							1 🗆 Yes 2 🗗 No
a or 2 be no	<u>=</u>	10e. Street and Nun	nber					10f. Zi	p Code				10g. C	Citizen of W	/hat Cou	intry?
th witl ms 23 must	Funeral		Still	water 1			- Local			3458				SA		
or iter	by Fu	11. Marital Status1 ☐ Never Marri	ied 2. □ v rMar	Armed	Decedent E d Forces? Yes 2 🕱 i		5. 13. V	Nas Dece f Yes, spe	dent of Hi cify Cuba	ispanic Origin ın, Mexican, P	i? (Sp Puerto	ecify Yes or No Rican, etc.)	-		- Ameri k, White	can Indian, etc.
urs afte ural",		3 🗌 Widowed		If Yes,		NO	1	I ☐ Yes	2 🖭 No	Specify:				Specify:	Wh	ite
72 hou "nat ledica	Completed	(Spe		nt's Education est grade comple	eted)		16a. Deced (Give I	kind of wo	rk done d	ation during most of	f work	king	16b.	Kind of Bu	siness li	ndustry
vithin iene. rr thar the M	S	Elementary/Second 1 2	onday (0-12)	Colleg	ge (1-4 or 5	+)		onorus cret	,				S+.	a t o	Con	ernment
filed wall Hyg	Be	17. Father's Name (I	First, Middle, i	Last)				, 1 0 0	ary	18. Mother's	s Nam	ne (First, Middle				ernmenc
ld be Menta iarkec atic e	욘	John L	awren	ce Alle	en					Vir	gi	inia M	. A	rmst	ron	g
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na		hip <i>(Type, Print)</i> inger/I	Husba	and						ral Route Numb : . , Ju				
1 and of Hea fitem		20a. Method of Disp					lace of Disposemetery, crem	sition (Nai	ne of			Date				own, State
Page ment tant: I		1 ½ J Burial 2 l 4 ☐ Donation		3 ☐ Removal fi Specify)	rom State		. Lin				ov y	2010	В:	rent	woo	d, MD
permit. Page 1 a Department of h Important: If ite any injury or ot		21. Signature of Funeral Service Licensee For Manneaut Soldress of Cooliny lins Funeral Home 500 University Blvd. W., Silve												me	Inc.	
40 = 60		23a. Part 1. Exter to	he disease of	complications th	hat cause	the death								Sil	ver	
hysician/		shock, or lear Immediate Cause (rt failure. List d	only one cause or	n each line							or respiratory a	11031,			Approximate Interval Between Onset and Death 4 hrs
Medical		Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of):												-	4 hrs	
Examiner	L	Sequentially list conditions, If dry, bedrig to immediate														20 yrs
git d	nine	If ary, leading to in cause. Enter Under	rlying	,												
executed ian and irial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	3 .	U	to (or as a	-		.c Ca	ardi	ovaas	cu	llar D	isea	ase	+	50 yrs
e be e) ysiciar e buria	I I	·														
ng phy as th	Med	IF FEMALE:										· ·				
ith cer ittendi or use	Physician/Medica	23b. Was decedent in the past 12 r	months?		ive Birth 2	2 🗌 Fetal	Ideath 3 🗌			у				23d. Date Mon		ery Day Year
ne des / the a ched t	ysic	1 🗌 Yes 2 🖫 9 🗌 Unknown	X No		Pregnant at Jnknown	time or a	eath 5 L	Other (sp	ресіту)					141011		Day Ica
that the ned by a deta	by PI	Part II. Other signifi	icant condition	ons contributing t	to death bu	ıt not resu	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did	tobacco	use contril	bute to t	he cause of death?
quires en sig ould ba		Carotid	Arte	ry Dise	ease,	Ну	perte	nsi	on,		_	1 x	Yes 2	l □ No	3 🗌 Pro	bably 4 🗆 Unknown
aw rec las be 2 sho	Completed	Hyperli	pidem	ia								24a. Was	psy	l pr	rior to co	psy findings available empletion of cause of
cate h												perf	ormed?		eath?	2 🗆 No
sician certifi rector	Be	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:					Othe	ace of Death (<i>k only one)</i> ome 5 ☐ Resi		v v S o	n's	House
y Phys er this eral di	e: 10	27. Manner of Death		28a. D	ate of injur	у	ER/Outpatien 28b. Time of		OA 8c. Injury		$\neg \neg$	ome 5 Resi 28d. Describe				()
anding sath. ir: Afte ne fun	licat	1 🔀 Natural 2 🔲 Accident	5 Pendir	gation	Aonth, Day,	Year)	injury	М	work'	? Yes 2□No	- 1		,	,		
to the hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ	ined 28e. Pl	ace of Injur uilding, etc.		me, farm, stre	et, factory	, office			28f. Location (City or To			or Rura	l Route Number,
Spital Dours a Deral I		29a, Certifier 1	Certifying	Physician: To th	ne best of n	ny knowle	edge, death o	ccured at	the time,	date and place	ce. ar	nd due to the ca	ause(s) a	nd manner	as state	ed.
ne Ho in 24 h he Fui pletec	Medical	(Check 2	Medical F	vaminer On the	hasis of av	amination	and/or investi	idation in	my opinio	n death accur	rrod a	t the time date	and place	a and dua:	to the or	ucalal and manner states
with a		29b. Signature and t	title of certifier	-971	_	7	M	290	. License	number	01/	,	29d. Da	ate signed	(Month,	Day, Year)
		1/4		, De	81 cm	w		\perp	MID	ddd	74	6	/ √∪	remi	つれ	4,2010
8		30. Name and addre	I had	who completed o	e ause of de	ath (Item	23a) (Type Pr	rint) c/cvi	110	MD	6	2085	0			
Sta Registr	te	31. Date filed (Month	n, Day, Year)	2010	2. Fegistrar	's Signatu	ure A	no Ken	,							Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Bella Solovyeva 1:16 am November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Olney Montgomery General Hospital Montaomeru Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Ukraine 1 □ M 2 🕱 F Months Days Hours Director 214-51-7861 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🎗 No Rockville. Maryland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12630 Veirs Mill Road. Apt. #410 20853 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify White Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Iosif Volfson Manya Feldman 19a. Informant's Name/Relationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valentin Gavrilovich Solovuev Veirs Mill Rd. 12630 #410. Rockville. MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 11/15/2010 Rockville, Maryland 4 Donation 5 Other (Specify) Menorah Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. NO # 1070 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart fai e. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HTHEROSCLEROTI SUDDEN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or jinjury Examine Due to for as a consequence on Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Other (specify) ☐ Pregnam.
☐ Unknown ∐ Yes ∠∎ □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has , page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29d. Date signed (Month. Dav. Year) 03041

Registrar

State

30. Name and address of person,

1810

ack

completed cause of death (Item 23a) (Type, Print)

5 2010

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV -2010 ear **Physician** 18, ANNA LEE SHANNON 11:59 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 220 S. FIRST ST. LAVALE ALLEGANY Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 X F 76 214-34-1476 Sept. 8, 1934 Director Maryland Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at MD Allegany LaVale 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 220 S. First St. 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1xxNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. College (1-4or 5+) Martin's Grocery Store Deli Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Shannon Anna T. (Small) Shannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mary Louise Ellsworth 220 S. First St., LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State St. Michaels Cemetery Nov. 20 2010 Frostburg, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part.I. Enter the charace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2ments Com ces -una /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1XYes 2□No 3□Probably 4□Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00055325 Nov 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walsh Rd Cumberland MD 21502 925 Bishop WONSOCIC SHIN 32. Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 31 2010 Year Physician/ P M 7:45 Iris Ileen Simmons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Oakland Garrett Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Funeral 1 □ M 2 🗓 F Days 10/16/1935 Freeport,WV 75 Director 236-56-1672 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No WV Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 22248 George Washington Hwy. 26705 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 Ith and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Therapist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Omer Daniel Shaffer Mary Hannah Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2733 Shady Dell Rd. Oakland, MD 21550 Diana Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aurora Cemetery 11/02/2010 Aurora, Hinkle Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service License SCOT POBox 186 Davis, WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death hour Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Tunknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 X N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at he Hospital or Attending Pin 24 hours after death.

He Funeral Director: After the pleted filled in by the funera 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragilioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 0 2 2010 32. Registrar's Signature

Goralski, M.D.

30. Name and address

Robert A.

parker

ho completed cause of death (Item 23a) (Type, Print)
alski, M.D. 311 N Fourth Street

10/31/2010

Oakland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marietta Townsend Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death lisburu Wiconico If Under 24 Hrs Hours Min 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Oct. 9, 1931 Mary land Director 220-26-1262 79 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 514 Village Court 21801 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th Peninsual Regional Medical College (1-4 or 5+) Certified Nursing Assistant Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Townsend Florence Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard C. Townsend, Sr. / Son 28206 Rockawalkin Ridge Road-Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens: 11/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Maryland Signatur of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATH Physician disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 \sum Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2/ No Other: Certificate: To 1 Tes 405PIC18 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ****Natural iniury 5 Pending 1 Yes 2 No Accident Investigation ☐ Acciden
☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

5/11

1733

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

WANDS

10058410

Division of Vital Records, P.O. Box 68760	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours often death	Ex
within 24 hours are locari. To the Funeral Director. After this certificate has been signed by the attending physician and	/led ami

			Plea	ase Type or			ndelible Inlantment of F					gible.	
	4	For State Registrar		State	n iviai yiai		tificate of E		alita iv		Reg. No	10	38125
Physicia		1. Decedent's Name	e (First, Middle C. Toler							2. Date of Dea Novemb	er 10 ^y 201	0 Year	3. Time of Death 6:18 р м
Medic Examin		4a. Facility Name (if		, give street and num of Greater W		1	4b. City, Town, or Rockville		of Death			ty of Death	erv
Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth	h	9. Birth	place (State or Foreign
Director		579-32-2 Usual Residence of		I LIVI ZOSI F		86 Yrs.				(Month, Day April 19	, 1924	Cour	ΛĎ
yland -f shov ed at	ctor	10a. State	10b. County	_		ity, Town or Lo							10d. Inside City Limits
or 28a e notifi	Director	MD 10e. Street and Num		e Georges		Capitol He	10f. Zip Code				10g. Citizen of	f What Cou	
h with ns 23a nust b	Funeral		echnut				20743				USA		
after deat Il", or iter xaminer I	þ	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		ried Armed Fo	2 🔀 No /e	l l	Vas Decedent of H f Yes, specify Cuba □ Yes 2 🏞 No	n, Mexican	, Puerto I	city Yes or No- Rican, etc.)		ice - Ameri ack, White, fy:	etc.
hours 'natura'	olete		15. Decede	Year or D nt's Education est grade completed		16a. Deced	lent's Usual Occup	ation	t of worki	na	16b. Kind of		Black idustry
ithin 72 ene. r than " the Me	Completed	Elementary/Seco		College (1			O NOT use retired)			ng	Someo	ne Els	e's Home
be filed w lental Hygi rked other ic event, t	வி	17. Father's Name (F	First, Middle, I	*		-1				(First, Middle, I		ne)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na		hip (Type, Print) Plater - so	on		ng Address (Street a						
Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disp 1 Burial 2 Donation	☐ Cremation	3 ☐ Removal from	State	cemetery, cren	sition (Name of natory or other place n Cemetery			Date per 19, 2010	20c. Location		_
permit. Departi Import any inj		21. Signature of Fur		icensee Lewel	e	22	Name and Address						578
Physician/		shock, or hear Immediate Cause (disease or conditio	rt failure. List o Final	complications that only one cause on ea	ach line.		er the mode of dyin		cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)		Due to	(or as a consec	quence of):	,						
ted J insit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	nmediate rlying iinjury	Due to	(or as a consec	quence of):	vasay	lar	di:	ese	,		
0 2.5	ical Ex	that initiated events resulting in death) l		Due to	(or as a consec	quence of):							
To the Hospital or Attending Physician: The law requires that the death certificate be within E. Junours after death certificate be within E. Junours after death. To the Euhorata Directors After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 1 9 ☐ Unknown	months? No	1 🔲 Live	gnant at ti <mark>me o</mark> f	tal death 3	Ectopic pregnand Other (specify)	су				Date of deliving	very Day Year
ires that th signed by Id be detac	þ	4	HTN	ons contributing to	death but not re	esulting in the u	inderlying cause giv	ven in Part	l.	23e. Did to			he cause of death?
he law requ te has beer age 2 shou	Completed	2) M - 2	<u>-</u>	-				_	24a. Was a autop perfor	osy rmed?		opsy findings available ompletion of cause of
ician: T sertifica ector, p	Be	25. Was case referre	_/	Hospital:			Oth	lace of Dea	th (Check		2.55 (10)		
ding Phys h. After this o funeral dir	cate: To	1 Yes 2 27. Manns of Death 1 Natural 2 Accident	5 🗌 Pendi	28a. Date	Inpatient 2 C of injury oth, Day, Year)	28b. Time of injury	28c. Injur	y at	. :	me 5 Resid			y)
al or Atten s after deal I Director: d in by the	Certificate:	3 Suicide 4 Homicide	6 Could	ained 28e. Place	e of Injury - At I ing, etc. <i>(Speci</i>		eet, factory, office			28f. Location (S City or Tow		ber or Rura	al Route Number,
he Hospit: Iin 24 hours he Funera Ipleted fille	Medical	(Check 2 only one) 3	Medical I	Nurse Practioner:	sis of examinati	on and/or inves	tigation, in my opinio	on, death o	ccurred at	the time, date a	nd place, and d	lue to the ca	ause(s) and manner stated.
To t To t		29b. Signature and	title of artifie	w	WD		29c. Licenso	e number 6 9 5	68		29d. Date sign	ed (Month,	Day, Year)
W 3		A-Chi	laka	who completed cau	se of death (Ite	m 23a) (Type, F	Print) Print) Rd 4	Poch	ville	MD.	2085	3	
Stat Registra		31. Date filed (Monti	th, Day, Year)	1777110	Redistrans Sidn	ature	parket	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6 UD AM rott Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood Mandrin Chesapeake Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 04-08-192 1 □ M 2 👿 F Months Davs Hours Min. Country) Mary I and 578-36-2356 Director 85 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 👿 No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6245 Mallard Lane within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) school library secretary public school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Everett Tucker Josephine Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin E. Trott, Jr., son 6275 Mallard Lane, Lothian, MD 20711 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Zion Cemetery 11-18-2010 Lothian, MD 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or imjury that initiated events resulting in death) Last that the death certificate be executed and -tran Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 certificate 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d, Date signed (Month, Day, Year) 006 15 fon who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per OPIGON WORLAND dRW) SVITEZIV 31. Date filed (Month, Day, Year, 32. Registra s Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#20b_PerFHPQC11-15-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:35 MME AM 115 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATYLAHO (DENETAL HOSP BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year Virginia **Director** 225-58-1664 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be 2124 McCulloh Street with 1 Funera 21217 U.S.A within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 Married than "natural", or ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shipping Ship Painter is marked other Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Tyler Beatrice Wynne 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10576 Cross Fox La. #A1, Columbia, Md. 21046 permit. Page 1 and 2 sh Department of Health al Important: If item 27 is Denice Tyler - Wife 11/15/bate2010_ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/15/201Beltsville,Md. Chesapeake Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eternal Faith Funeral 625 Allentown Rd., Camp Springs, Md. e of Fun Service Licenses Svc. 20746 625 M01576 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Due or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067207 2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Mary land General Hospital Baltimore MD 827 Linden Blvd, mary land 31. Date filed (Month, Day, Year 32. Registrer's Sign dure State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2010 Nan Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) County of Death Examiner Prince Georges Maryland Hospita linton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Funeral 1 □ M 2**X** F Days Hours MARCH II 225-21-7519 Director If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Funeral Director 1 XYes 2 ☐ No Alexandria 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 22309 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) medical equipment Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Page 1 and 2 should of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place-Alexandria, VA 22309 Dorothy Smith mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory litan Cremation 1/20/2010 Alexandria VA 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licensee 814 Franklin St. Alexandria, VA 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFARCTION Immediate Cause (Final disease or condition MYOCARDIAL Physician Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 📈 Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CAROVARY ANTERY DISEASE After this certificate 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗓 No Other: မြ 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After work' M-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year) D48158 exceuses me and address of person who completed cause of death (Item 23a) (Type, Print) PIKE UPPER MARLEBORD MD 20772 9628 MARLBORD 32. Registra 's Signature 31. Date filed (Month, Day State NOV 1 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 11 per spouse 6912 7/2/1 dk
State of Maryland Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Lewis Tuck 2010 November 2:30 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Pin Oak Village Apartments Bowie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1943 | 9. Birthplace (State or Foreign (Month, Day, Year) 23, North Carolina 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 X M 2 🗆 F **Director** 245-66-4853 67 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Prince Georges Bowie 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 20716 16010 Excalibur Road; Apt. A303 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 🛣 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** "natural", 3 Widowed 4 Di Specify: Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) Washington Post Elementary/Seconday (0-12) College (1-4 or 5+) Mail Handler Newspaper 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Alexander Gaston Tuck Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Anthony Minor (Son) - 6th Street; Apt. 13; Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Nov. 18, 201 4 ☐ Donation 5 ☐ Other (Specify) Meritage Memorial Cemetery Waldorf, Maryland 21. Si nature o Funeral Service Lio rse 22. Name and Address of Facility R. N. Horton Company Morticians, curval Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) d Examiner de la compa Sequentially list conditions, if any, leading to immediate page. Fater Indenting Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Other: 2 No 욘 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 🗌 No Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD19948 17, 2010 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ethiopia Abebe, M.D.; 1221 Mercantile Lane; Largo, Maryland 20774 31. Date filed (Month, Day 32. Registrar Signat State NOV 1 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Of IVI	ai yiai iu	•	rificate of L			Reg. No.	2010	38130
	Discostation	/	1. Decedent's Name (First, Middle, Last)					2. Date of De		y Year	3. Time of Death
	Physicia Media		Anne Parker Tuck					Month November	er 15	<u>5, 2010</u>	1:50 A M
-	Examir	er	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location of Dea	th	4c.	County of Death	ı
-	<u></u>		Suburban Hospital				esda			Montgon	
	Funeral Director		116-24-6162 1 □ M 2X F	je (In yrs. last i 86	Yrs.	Months Days	If Under 24 Hr Hours Mir		y, Year) 192	Cou	nplace (State or Foreign Intry) China
	ind show at	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ation			-		10d. Inside City Limits
	faryla Ba-f s tified	ect	Maryland Montgomery		Bet	hesda					1 ☐ Yes 2 🔀 No
	the N	اقا	10e. Street and Number		_	10f. Zip Code			10g. Cit	izen of What Co	untry?
	s 23a	Funeral Director	8300 Burdette Road			208	317		Uı	nited St	ates
	death item ner n		11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (s n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Amer Black, White	
36	al", or	d by	1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates.1	No	1	☐ Yes 2 🏞 No					ite
9	hours natur iical I	lete	15. Decedent's Education		16a. Decede	ent's Usual Occup	ation		16b. Ki	ind of Business I	ndustry
Maryland 21215-0036	iin 72 ie. han "	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 1	5+)	life. DO	nd of work done of NOT use retired)	during most of w	orking			
121	d with tygier ther t nt, th	ادہ ا	4		Hon	emaker	40.14.0.1.11	(F) . (A E L P .	•	Own Home	-
anc	oe file antal F ced o	70 E	17. Father's Name (First, Middle, Last) Albert George Parker, Jr	•				ame <i>(First, Middle,</i> arine Mac			
Ž	ould Ind Me		19a. Informant's Name/Relationship (Type, Print)		19h Mailine	Address (Street		ural Route Numbe			Code)
	d 2 sh alth an 27 is		Mary T. Staley/daughter			Ogden Ro		hesda, Ma			
Jre,	1 and of Hear		20a. Method of Disposition	20b. Plac		ition (Name of atory or other place		Date	_	ocation - City or	
<u>=</u>	Page nent ant: It ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					/16/2010	Woo	odbine,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signarile of Funeral Service Licenses	340005				ion Serv			
		_	23a. Parl. Enter the disease, or complications that caused	M0095 d the death. D						arksviii	e, MD 21029 Approximate
	Pnysician/		shočk, or heart failure. List only one cause on each lin-	e.							Interval Between Onset and Death
). Medical		disease or condition resulting in death) a. Supra	a consequen	ular ce of):	Tachycar	dia				days
	Examiner	<u>. </u>	Sequentially list conditions. Pneumo	nia							a week
	3 # E	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								,
	and and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as	idium a consequenc		.cıle			_		a week
0	rificate be executed ng physician and as as the burial-transit			y Trac	ct Inf	ection					a week
376	ficate g phy as the	Med	TE FEMALE								
39 ×	attending I for use as	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome			Ectopic pregnand	÷y		- 1	23d. Date of del	
P.O. Box 68760	t the death by the attertached for	Physician/Medical	1 ☐ Yes 2 🛣 No 4 ☐ Pregnant a 9 ☐ Unknown	it time of deat	th 5 🗌	Other (specify)				Month	Day Year
P.0	hat the	by Ph	Part II. Other significant conditions contributing to death b	out not resulti	ing in the un	derlying cause giv	ven in Part I.	23e. Did t	орассо и	se contribute to	the cause of death?
S,	uires that in signed uld be del	ed b	Dementia					10	Yes 2	☑ No 3 🗆 Pr	obably 4 🗆 Unknown
Sor	has been sign 2 should	Completed	Diarrhea					24a, Was		24b. Were aut	opsy findings available completion of cause of
Re	The la ate ha	Con							ormed? 2 🔀 No	death?	2 🗆 No
tal	nysician: The nis certificate director, pag	Be	25. Was case referred to medical examiner?			26. Pl	ace of Death (Ch	eck only one)			
Ž	Physic this cral dir	2	1 ☐ Yes 2 X No 1 ☐ Inpat 27. Manner of Death 28a. Date of inju	ient 2 ER	NOutpatient Bb. Time of	3 DOA 28c. Injur	4 ☐ Nursing	Home 5 Resident			(fy)
o u	nding Ph ith. : After th	cate	1 ☑Natural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation		injury	work		200. Describe t	iow injury	y occurred	
Division of Vital Records,	I or Attending after death. Director: After I in by the funer	ertificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj	ury - At home	e, farm, stree	et, factory, office		28f. Location (S			al Route Number,
<u>S</u>	spital or ours after ours after ours after ours after ourself our filled in 1	O									7
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of 6 only one) 3 Certifying Nurse Practioner: To the	examination an	nd/or investig	gation, in my opinio	on, death occurre	d at the time, date a	and place,	, and due to the o	ause(s) and manner stated.
	vithir comp	Σ	29b. Signature and title of certified			29c. License				te signed (Month	
			1.1000			10 4	3404		1	11112	10
	124		30. Name and address of person who completed cause of a TWO Hollar WD 9600 CI			nRd, B	zthorda	MD 208	314	Sulace	ban Hospital
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 1 6 2010 32. Begistr	ar's Signatur		arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:15 P M November Mary Jones Virginia Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Crofton Convalescent Center Anne Arundel Crofton 8. Date of Birth
(Month, Day, Year)
NOV 17, 1931 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months 1 M 2 TX Davs Hours Min. Maryland Director 220-30-6502 78 Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sh notified a 1X Yes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? be ns 23a r c must h Funeral 913 Central Street United States 21401 items 2 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11 Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: African-American Completed 3 Wildowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Domestic Worker HouseKeeping Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I: ant: If item 27 is marked o Annie Boardley Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elois D. Alexander/daughter 913 Central Street Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/15/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Modes Cremation Service P.O. Box 784 Thomas Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 anita 23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) vears Dementia Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions Examine Due to for as a consumence of if ally, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? detached for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 2 No ☐ Yes 2 🛛 No Yes Yes Physician: Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2X No Other: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🔣 Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funeral 5 Pending injury work 1 Natural 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 20 0

Registrar

State

14300 Gallant Fox Lane. Suite 222.

Bowie, Maryland 20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Green

Rakesh Arora, M.D.

T 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, Day Physician/ Month NOV • 2010 BOYD TWIGG 18:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY ALLEGANY HEALTH NURSING & REHAB CUMBERLAND If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🕱 F Months Hours AUG. 23, 1930 FROSTBURG MD 220-28-9665 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No FROSTBURG ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U. S. A. 21532 11325 UPPER GEORGES CRK RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 X Married 1950 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced 1954 Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STEEL WORKER STEEL INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BOYD E. TWIGG JEANETTE (MCDONALD) TWIGG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532 11325 UPPER GEORGES CRK RD, FROSTBURG, MD SYLVIA (SCOTT) TWIGG WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1, 2010 1 🕱 Burial 2 🗌 Cremation 3 🗆 Removal from State DEC FLINTSTONE, MD MSVC ROCKY GAP CEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAFER FUNERAL SERVICE, P.A. Signature of Funeral Service Licenses LAVALE, 1302 NATIONAL HWY., 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1NS) EN An 6 Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown detached g Unknown υ υπε runeral Urector: After this certificate has been signed by το completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signatur and title of certifier 29c. License number 2 NOV

State Registrar

31. Date filed (Month, Day Year)

DHMH 17 Rev 7/2009

Barrera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, perpHYS, G913, 3/16/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarice White November 2010 9:00 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Braddock Heights Vindobona Nursing Home Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 227-28-9606 1 M 2 X F Months Hours Min Country) Virginia Director 86 Aug. Usual Residence of Decedent 28a-f show 10b. County 10a, State with the Maryland 10c. City. Town or Location Examiner must be notified at Director 10d. Inside City Limits Frederick Braddock Heights Md. Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 6012 Jefferson Blvd. 21714 U.S.A items ? filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Hygiene. Food Service Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Franklin Blosser Mary M. Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9153 Crystal Falls Dr. Boonsboro, Md. 21713 Keith White (Son) Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Data 4 Smithsburg Crematory or other place) Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Honset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month by the detached Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ઁ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only on 29b. Signature of certifie ပ 29d. Date signed (Month, Day, Year) 200 62223 Name and address of person who completed cause of death (Item 23a) (Type, Print) REJOUCE, ND UTO2 1967J DLIVE LAYERN A LALUM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month W. Moore Rubv VanMeter 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner c. County of Death
HIRGANY 4b. City, Town, or Location of Death WMHS-Regional Medical Center mberlana 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Months Hours Min Oct TO ^{ear}1929 Director 213-26-1850 81 Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. interest is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cresaptown 1 □**X**/es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14905 Lone Oak Road 21502 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner Boutique Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Alvie Moore Halda Wilma Wilt other traumatic 19a. Informant's Name/Relationship (Type, Print)
Darrell Vanmeter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14905 Lone Oak Road Cresaptown MD 21502 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Memorial Gardens 12/2/201 4 Denation 5 Other (Specify) LaVale MD Signature Funeral Se Age Licensee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ vebrow disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 Yes 2 No Acciden

Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mh and address of person who complet of death (Item 23a) (Type, Print) 160 Mas Registrar's Signature Ü State 0 Museum

DHMH 17 Rev 7/2009 7 De

Registrar

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Fun Dire

		•	/pe or Print in E State of Marylan				•		_				
	-	- State Registra Amend#26.PerF						Reg. No.	CUI U	35133			
sicia		1. Decedent's Name (First, Middle, Last) Jimmie S. Vau	ahan				2. Date of D Month	Day	Yea 11.20	M			
ledica amine		4a. Facility Name (If not institution, give st		4	b. City, Town,	or Location of Deat			County of De				
		Fort Washington	Medical Co	enter	Fort		gton	Pr		Georges irthplace (State or Foreign			
eral ctor		5. Social Security Number 6. Sex 15x	7. Age (In yrs.	Yrs.	Months Days					Country)			
AO,		Usual Residence of Decedent		7.0			INOV.	1413	740 V				
d at	<u>_</u>	10a. State 10b. County		y, Town or Locat						10d. Inside City Limits 1 □ Yes 2 □ No			
offile	Director	MD PG 10e. Street and Number			Hill 10f. Zip Code			10a. Cit	izen of What (
2		712 Leyte Place				745			ted S				
9	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	s Decedent of	Hispanic Origin? (S	Specify Yes or I			nerican Indian,			
xarting	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐ No If Yes, Give 196	1- 10	Yes 2 No		to riseari, every		Specify: B1				
Scal E	sted	15. Decedent's Education (Specify only highest grade	ation	16a. Deceder	nt's Usual Occu	ipation	rkina	16b. K	ind of Busines				
any Injury or other traumatic event, the Medical Evanting must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire	e during most of wo ed) enance	nuing	Go	overnm	nent			
event, 1	Be C	17. Father's Name (First, Middle, Last)	1	_		18. Mother's Na	me (First, Midd	lle, Maiden	Surname)				
natic	၉	Sandy Vaughan		405 84-18	Address (Class	Marth		vin	as Taura State	Zio Codo)			
r traur		19a. Informant's Name/Relationship (Typ Joann R. Vaughan	1	712 Tu	evte F	lace		nber, Uny C	or rown, state	e, 21p Code)			
r othe	Ì	20a. Method of Disposition	20b. P	Place of Dispositi emetery, cremai	ion (Name of tory or other pla	MD 207	Date 19/10	20c. L	ocation - City	or Town, State			
lury o		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Md	. Vete	rans C	emetery				nam,MD			
any Inj once.		21. Signature of Funeral Service Licenses	Hope			ress of Facility H				F.H. R,MD.20746			
	-	23a. Par 1. Finter the disease, or complic	ations that caus d he death					-	LCIano	Approximate Interval Between			
ian ical ner		sho % or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or a * consequence of): Seguentially list conditions.											
JISI	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequent	uence of):									
,	ш	that initiated events c. resulting in death) Last	Due to (or as a consequence	uence of):									
completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	I death 3 🗆 E	Ectopic pregnar Other (specify)				23d. Date of Month	delivery Day Year			
be deta	by Pr	Part II. Other significant conditions cont	ributing to death but not res	ulting in the unde	erlying cause g	iven in Part I.				e to the cause of death?			
hould	eted]Yes 2					
ge 2 s	Completed			<u> </u>			24a. Wau au pe	topsy rformed	, prior death	autopsy findings available to completion of cause of 1?			
or, pa	0	25. Was case referred to medical				26. Place of De	1 ☐ Ye: ath (Check onl		1 □ Y	es 2 MNo			
direc	ල ල	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 00A O	ther: 4 \(\sum \) Nursing			6 ☐ Other (S	Specify)			
funeral	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inj Wo	ury at ork? ⊒Yes 2 ⊒No	28d. Describ	e how inju	ry occurred				
d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stree (y)			28f. Location City or	o (Street a Town, State	nd Number or e)	Rural Route Number,			
oletely fille	Medical C		ician: To the best of my kno er: On the basis of examina and manner stated.										
comp	Me	29b. Signature and title of certifier				nse number		29d. Da	ate signed (Me	onth, Day, Year)			
		I Cul other of	np		1)0	105601	/	11	111	10			
t		30. Name and address of person who cor	/ +1001	n 23a) (Type, Pr	ston	Rd., For	+ was	shin	gton,	MD. 20744			
Stat gistra		31. Date filed (Month, Day, Year) NOV 1 7 2010	32. Registrar's Sign	are	,								

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11/13/ Physician/ ANNETTE WILLIAMS 2010 2:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) **D** Δ 1 □ M 2 🖾 F Months Days Hours Min 174-42-1229 New Kensington Director 60 /21/1949 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27: is marked other than "natural", or items 23a or 28a-f sho wither traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9820 Green Apple Turn 20772 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married 2 K No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jeremiah Henry Williams Dorothy Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr Dorothy C. Lowe / Sister 9820 Green Apple Turn Upper Marlboro, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill 11/20/2010 | Suitland, Maryland of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final MOCARDIAL Onset and Death Physician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATHEROSCLEROSIS ORONARI Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 2 3 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ GMPHYSEMA Completed 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has HYPERTENSCON performed? death? certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No Accident Investigation Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0057800 MD

ir_

State Registrar

DHMH 17 Rev 7/2009

5711 Sagues ave #

Riverdale,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHRAF

32. Registrar's Sign

MUHAMMAD

NOV 1 9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For	State of	Maryland .	•	rtment of F		and M	1ental Hy	giene		
			State Registrar			Cer	tificate of L	Death			Reg. No.	2010	39137
	Physicia	n/	1. Decedent's Name (First, Middle, L.							Date of De Month	Day	Year	3. Time of Death
	Medic			lliams						Novembe		2010	18:33 P M
	Examin	er	4a. Facility Name (if not institution, gi				4b. City, Town, or		of Death			ounty of Death	1-
-			Southern Mary 1 5. Social Security Number 6.		tal Age (In yrs. last I	hirthday)	Clint If Under 1 Year		24 Hrs.	8. Date of Bir	th	ince Ge	place (State or Foreign
	Funeral Director			1 □ M 2 💢 F	55	Yrs.	Months Days	Hours	Min.	(Month, Da May 12	1955	Cour	
			Usual Residence of Decedent							, , , , , ,			
	/land f sho ed at	io	10a. State 10b. County		10c. City, To	own or Loc	ation]	10d. Inside City Limits
	Mar 28a- notifie)ire	Maryland Prince	George's	Mitcl	nellv							1X Yes 2 No
	th the	Funeral Director	10e. Street and Number 2007 Clearwood	Drive			10f. Zip Code 20721			i	· ·	n of What Cou	
	ath w	nue	11. Marital Status	12. Was Decede	nt Ever in U.S.	13 V	Vas Decedent of H	ispanic Orio	ain? (Spe	cify Yes or No-		ted Sta	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Force	s? X No	l1	Yes, specify Cuba ☐ Yes 2 X No	ın, Mexican	, Puerto			Black, White, ecify: B1a	etc.
2-0	hour fnatu dical	Completed	15. Decedent's (Specify only highest		1		ent's Usual Occup		t of worki	na	16b. Kind	of Business In	dustry
2	nin 72 ne. than '	E O	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. D	O NOT use retired)	Exec	utiv	е			
2	filed within tal Hygiene. ed other than event, the N	BeC	47. Estherite News (First Middle Lee			Admi	nistrati			ant e (First, Middle,		vate	
anc	ntal h	70 E	17. Father's Name (First, Middle, Last							A McCu		,	
7	2 should be th and Ment 27 is marker traumatic e	ľ	Frederick L. W			19h Mailin	g Address (Street			*-			Code)
	12 sh alth ar 27 is r trau		Leslie C. Perry		I .		Clearwo						
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spe		ceme	eterv. cren	sition (Name of patory or other place) lem. Ceme	tery	_	Oate 0/2010		tion - City or T	
Baltir	permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Me once.		21. Signature of Funeral Service Lice	_	TOR	22	Name and Addres	ss of Facilit	y St	ewart I	Tunera	1 Home	, Inc.
			23a. Pa. 1. Enter the disease, ir co	mplications that cau	sed the death. D								Approximate
	Physician/		shook, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	fat	-11	Car	dia	P	Asis	Then	121	Interval Between Onset and Death
-	Medical Examiner		resulting in death)	Due to (or	as a consequenc	ce of):	1	1					
	LAdimilei	ř	Sequentially list randitions	b	111	20	45M5	101					
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or	as a consequenc	ce of):							
	ecute and Il-tran	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequenc	ce of):							
0	ate be executed ohysician and the burial-transit	dical		■ d									
120	icate	led.		_ u									
Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director. After this certificate has been signed by the attending physician and funeral Director, page 2 should be detached for use as the burial-transit attending the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 D Fetal dent at time of deat	eath 3 🗌	Ectopic pregnand Other (specify)	су			230	d. Date of delive Month	very Day Yea r
P.O.	es that the dec signed by the a be detached i		Part II. Other significant conditions	contributing to deat	th but not resultir	ng in the u	nderlying cause gi	ven in Part	l.	23e. Did t	obacco use	contribute to t	he cause of death?
S, F	ires the signer of the signer	Completed by						_		1 🗆	Yes 2	No 3 ☐ Pro	obably 4 🗆 Unknown
ord	require been si should I	Set	1							24a. Was		24b. Were auto	ppsy findings available
ec	The law cate has page 2	l E								auto perfo	psy ormed? 2 No	death?	ompletion of cause of
E E	sician: The certificate I rector, pagi	BeC	25. Was case referred to medical				26. P	ace of Dea	th (Check		2 🗀 110]_	1 2 100	
Vit	Physician: this certific al director,	10 6	examiner? 1 Yes 2 No	Hospital:	patient 2 ER	/Outpatier	t_3 🗆 DOA Oth	er: 4 🗌 Nı	ursing Ho	me 5 🗆 Resi	dence 6	Other (Specif	y)
of	iding Phy th. After thi funeral		27, Manner Death 1 atural 5 Pending	28a. Date of (Month,	injury 28 Day, Year)	b. Time of injury	28c. Injur work	⟨?	- 1	28d. Describe l	how injury o	ccurred	
ion	tendi leath. or: A	ifica	2 Accident Investigat 3 Suicide 6 Could no	ho				Yes 2	No No				
Division of Vital Records,	al or At s after d il Direct ed in by	Certificate:	4 Homicide determine	28e. Place of building	Injury - At home , etc. <i>(Specify)</i>	, farm, stre	eet, factory, office			28f. Location (City or Tox		lumber or Rure	l Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Exa	nysician: To the bes miner: On the basis urse Practioner: To	of examination an	d/or invest	igation, in my opinie	on, death or	ccurred at	the time, date	and place, ar	nd due to the ca	ause(s) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifier	/	(29c, Licens	e number			29d. Date s	signed (Month,	Day, Year)
			Milled				109	532	80		17.	-13-1	'
R	2		30. Name and address of person wh	completed cause	of death (Item 23	a) (Type, F	rint)	hd.	Cli	nton.	md	2073	5
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 9 2010	Seneral 32. Reg	Istrar's Signature	Kel							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4,2018 Month Facility Name (If not institution, give street and number) 4c. County of Death VER RHOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) A Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1**X** M 2□ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WORTON 1 ☐Yes 2 ☐ No KEN 10e. Street and Number 10g. Citizen of What Country? 4 LAMBS USA 21678 MEADOW Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST CAMPBELL'S SOUP CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WINTERS JAMES LILLIAN MAE 40 LLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 💍 🖇 😂 JACQUELINEBANKS SISTER DAK STREET APT 2713 LINDENWALL, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/10 DIRECTCREMATIONAL DOVER, DE Signature of Funeral Service Lie 22. Name and Address of Facility Hish ChosTORTOWN, md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCER LUNG MONTHS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□No 2 **N**O 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury

Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760. attending p for use signed by the a cate has been signal page 2 should b After this funeral nours after death.

neral Director; Aft

filled in by the fun Hospital 24 hours a

Physician /Medical

Examiner

Director

Completed by Funeral

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Maryland Examiner must be notified at appear.

Physician

Baltimore, Maryland 21215-0036

/Medical Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be Certification: To 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

planen MD D0066441

29d. Date signed (Month, Day, Year) OCTOBER 14 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOLLI, RAMES H (ODBROWN STREET, CHESTERTOWN, MD

KOLLI, RAMESH

31. Date filed (Month, Day, Year)

32. Registars Signature

State Registrar

To the I within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 10e State Registrar 10/22/2010, M.S. Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:00 LOMAN TEORGE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERRI KENT LHESTERTOWN . Age (In yrs. last birthday) Yrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 1 X M 2 □ F Days Min Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 📉 No KENT CHESTERTOWN 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 21620 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 ☐ No 1954

If Yes, Give 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 1974 Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MILITARY (ARMY MILITARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WASAINGTIM WARNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE WARNER WIFE TERTOWN, MD 21620 20b. Place of Disposition (Name of Oliver Communication) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State WORTON, MD 10/16/10 4 ☐ Donation 5 ☐ Other (Specify) NEW CHRISTIAN CHAPEL BENNIESMITHFUNERAL HOME Sid 22. Name and Address of Facility of Funeral Service Licens 855 HIGHST CHESTERTOWN 23a. Parl 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for 5 Other (specify) Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) vame and address of person who completed car Sen egistrar's Signature State cassas Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Jacqueline Willette Nov. 8 10:00a ^M Mood Medical 4a. Facility Name (if not institution, give street and number) Birchwood Group Home 18301 Indian Head Examiner 4b. City, Town, or Location of Death 4c. County of Death Inc Accokeek Prince George Social Security Number 8. Date of Birth (Month, Day, Year) 9-28-1949 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 XF Country) 578-66-5130 Director Maryland Usual Residence of Decedent 28a-f shov be filed within 72 hours after death with the Maryland must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No Maryland Prince George Upper Marlboro 10e. Street and Number ö 10g. Citizen of What Country? Funeral items 23a 10208 Brookhaven Lane 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ō 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 X Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Aide Day Care event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Frederick D Clay Mamie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Terri Grimes/ Daughter 10208 Brookhaven Ln, Upper Marlboro MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Alexandria Metropolitan 11/13/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility RO Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Squamous Cell Cancer Of Base of Tongue disease or condition Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo Day Year Pregnant at time of death signed by the sid be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been sig 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy nis certificate h I director, page 1 ☐ Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide within 24 hours after death

To the Funeral Director. /
completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State To the Hospital Medical TX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) november 11 2010

7LB - State

Registrar

MATILDA

31. Date filed (Month, Day, Year)

LANG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 5 2010

1221

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 8 Winslow Physician/ 5:37 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's 9. Birthplace (State or Foreign Country) D.C. If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Social Security Number 8. Date of Birth Funeral Months Days Hours 52 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director Prince 1 XYes 2 ☐ No MD BELTSVILL 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20705 100mico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married 'natural", or Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) PEIVATE SUPBENISOE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WINSLOW WINFIELD JEAN PB66Y NORMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEPHANIES WINSIOW WICOMICO AVENUE BELTSVILLE, HD 20705 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State RIVERDARE, MO RIVERDALE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 814 UPSHUR ST NW BLAWCHI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ hour disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Artery Disease unknown orondry Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Cardiovascular Disease Unknown Hypertensive attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Yes 2 No led by the sidetached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Morbid Obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🗙 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred n 24 hours after death.

e Funeral Director: After the funeral oleted filled in by the funeral controls. Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van Dusen Road Laurel Regional Hospital Wang Koon, MD aurel, MD 31. Date filed (Month, Day, Year, 32. Registra s Signat State **6 2010** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day d5 2010 JULIA A. WILLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death oasta rospice lisbur a) comico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Funeral Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 2/3/194 Hours 1 □ M 2**X** F Days Min MARYLAND Director 215-38-0317 69 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND DORCHESTER **CAMBRIDGE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 1312 COLONIAL AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 Yes 2X No If Yes, Give Completed by 1 ☐ Yes 2 🗶 No Specify: Specify 3 Divorced 4 Divorced Year or Dates WHITE Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) **ASSEMBLER** ELECTRONIC MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) HANK GREENE HILDA MCCLAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILLIP W. WILLEY, SR. / HUSBAND 1312 COLONIAL AVE., CAMBRIDGE, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2010 CAMBRIDGE, MD DORCHESTER MEMORIAL PARK Signature of Funeral Service Licensee 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CIRRHOSIS Physician/ LIVBA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician at for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) the a 1 Yes 2 to 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No cate has been siç ; page 2 should b Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfor death? To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 🗌 Yes 24 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOSPICA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only on Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n1802 130 HUMUN WAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day Medical Grace Margaret Wingate November 12, 2010 6:55 pm M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens
Social Security Number 6. S Assisted Livino Columbia Howard **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Davs Director Hours 027-12-9095 Country March 16. 1921 Massachusetts Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoulury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits Virginia Fairfax Falls Church 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Cherri Drive 22043 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes 2 X No Yes, Give Black, White, etc. Completed 3 Divorced 1 Yes 2 No Specify swhite Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George J. McNeill Elizabeth Leach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Karen Ault (Daughter)</u> 13327 Elliott Drive, Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 20c. Location - City or Town, State x☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 11/17/10 | Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home CC0455 1102 W. Broad St., Falls Church, VA Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Onset and Death Cerebral Infarction Medical 5 Days Due to (or as a consequence of Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated cause. 15 Years Examine Due to (or as a consequence of burial-transit Essential Hypertension 15 Years and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the human. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 🔀 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 4 Nursing Home 5 Residence 6 X Other (Specify) Living Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3

State Registrar 29b. Signature and title of certifier

Harry Li, MD

31. Date filed (Month, Day, Year

NOV 1 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Snowden River Pkwy

29c. License number

301,

D 56531

29d. Date signed (Month, Day, Year)

November 13, 2010

Columbia, Maryland 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year} Willis Ethel 8:00 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard Fulton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Months Hours Min Director 545-66-3617 90 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20759 11584 Scaggsville Rd. USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛛 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black jed 3 X Widowed 4 Divorced Complet 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important If item 27 is marked other than "n:
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Turner Nellie Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8905 Slaptown Rd. Hancock, MD. 21750 Delores Allen - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2010 Los Angeles, CA Inglewood Cemetery 21. Signature of Funeral Service Licensee Marshall March F/H 22. Name and Address of Facility 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician backed for use as the buria Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospina.

Within 24 hours after deam.
To the Funeral Director: After this certinua...

completed filled in by the funeral director, par this certificate Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 No Other: grouphome ဂ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of certifler

31. Date filed (Month, Day, Year) NOV 1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi
201-109 ISECK RVW Meck Koad

30641

10-08413	
DeAndre White	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

o, mare vilke	1- For State Registrar Amend#19a PerFHPGC11-17-10C 1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. No.	38145
Physician/	()		2. Date of Death Month Day Year November 3, 2010	3. Time of Death 1033 hrs
Medical Examine	DeAndre Lorenzo White 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		
	University Hospital	Baltimore		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 217-37-8011 1⊠м 2□F 17	st birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir Yrs.	Forei	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Fown or Location		10d. Inside City Limits
	MD Charles	Waldorf		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?
ith the 23a or notifie		20601 3. Vas Decedent of Hispanic Origin? (S	USA	rican Indian, Black,
or items 23 must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert		
ral", or	3 Widowed 4 Divorced if res, Give rear or Dates:	1 Yes 2 No specify:	Specify: Bla	
2 hours "natur		16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	tired)	
5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examiner Completed by	. 75 J	Student	Educa	tion
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director			e (First, Middle, Maiden Surname) y1 Ingram	
imore, MD 21215-C Pages 1 and 2 should be filed to ment of Health and Mental Hygi tant: If item 27 is marked oth or other traumatic event, the To Be Cc	A CONTRACT OF THE PARTY OF THE	19b. Mailing Address (Street and Number or		e, Zip Code)
MD d 2 sho lith and n 27 is	Cheryl Ingram / mother	3383 Ryon Ct., Wald		
or Heal	1 Burial 2 Cremation 3 Removal from State	ace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location - City or	
Pag Pag	4 Donation 5 Other Specify: Res	Surrection Cemetery 11. 22. Name and Address of Facility 7	/11/2010 Clinton crickland Funeral S	
Balti permit. Departu Import	Exilo Stricland	6500 Allentown Ro	d., Camp Springs, N	
Physician	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
IV edical. Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)			Death
	Sequentially list conditions, b.	•		
iner	if any, leading to immediate Due to (or as a consequence of)	:		
760, ficate be executed sphysician and the bunal - transit		:		
60, ate be execu hysician and te burial - tra	UNPENDED AMENDED			<u> </u>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi ledical Certification: To Be Completed by Physician/Medical Exhibital Certification: To Be Completed by Physician Certification:		2 Fetal death 3 Ectopic pregr	ancy 23d. Date of deliver	ry Day Year
b. Bc the dec	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
P.O. res that the signed by be detacked by P.O.			1 Yes 2 ✓ No 3 Pro	bably 4 Unknown
Records, The law requires fricate has been signage 2 should by Completed			autopsy prior to	utopsy findings available completion of cause of
Recc The lay cate ha			performed? death? 1 ✓ Yes 2 No 1 ✓ Y	es 2 No
Vital ysician: his certifi director,	25. Was case referred to medical examiner? [Hospital: 4] Insertion 2]	26.Place of Death (Check ER/Outpatient 3 DOA Other'4 Nurs	only one) ng Home 5 Residence 6 Othe	er.
Division of Vital Records, tal or Attending Physician: The law requiring after death. al Director: After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion trendin death. tror: A tre fu	1 Natural 5 Pending NoV 2, 2010 Nov 2, 20	1531 hrs 1 Yes 2 V No	Driver auto auto collision	
Division o spital or Attending tours after death, neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Major Road	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) SB Route 301 at Brandywine Road	
Division of Norther Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Certification: Teledical Certification: T		e, death occurred at the time, date and place, an	d due to the cause(s) and manner as sta	ted.
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the pasis of examination an and manner stated.	d/or investigation, in my opinion, death occurred	at the time, date and place, and due to t	he cause(s)
_ ≥	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo	
4	30. Name and address of person who completed cause of death (Item :			
OCME	Mary G. Rippie MD. Deputy Chief Medical Exam	niner 111 Penn Street, Baltimore,	MD 21201	
State Registra		iks		

10-08796 Charles M. Willis

Physician/ Medical Examine

> **Funeral** Director

> > or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene.

Physician /Medical

Examiner

Accident

3 V Suicide

Examiner

Physician/Medical

\$

Be Completed

Certification:

Medical

Director 10e. S 47

Funeral

<u>۾</u>

Be Completed

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For State	te of Maryland				i Mentai i	⊣ygiene	201	0 3814
egistrar		Certific	ate of	Death		Re	g. No.	
. Decedent's Name (First, Middle,	Last)					Date of Death Month	Day Year	3. Time of Death
Charles M		illis				November	16, 2010	1141 hrs
a. Facility Name (if not institution,	give street and number)	4	b. City, Town, or L	ocation of Dea	ith	4c. County of E	Death
47988 Turkey Neck Ro	ad		_	Lexington Pa	ark		St. Mary's	
Social Security Number 6	. Sex 7. As	ge (In yrs. last bir	thday)	If Under 1 Year	If Under 24H		(MM/DD/YYYY)	Birthplace (State or Foreign Country)
	1 X M 2 F	53	Yrs.	Months Days	Hours M	02/13	/1957 I	Rhode Island
sual Residence of Decedent Da, State 10b. County		10c. City, Town	or Locatio	on.		-		10d. Inside City Limits
								1 Yes 2 No
	Mary's	Le	xing	ton Park				
e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
47988 Turkey No	ck Road			2065	3		USA	
. Marital Status	12. Was Deceden					Specify Yes or No-		merican Indian, Black,
X Never Married 2 Mar	ried Armed Forces	? 2 X No	I If Ye	es, specify Cuban,	wexican, Puer	to Kican, etc.)	White, e	IC.
Widowed 4 Divor	ced If Yes, Give Year	٠	1	Yes 2X No	specify:		Specify:	White
5. Decedent's Education (Specif				's Usual Occupation			16b. Kind of Busin	ess/Industry
Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working life.	DO NOT use re	etired)		
12			Mech	anic			Automo	otive
Father's Name (First, Middle, L	ast)			1	8.Mother's Nar	ne (First, Middle, M	aiden Sumame)	
Martin Jose	oh Willis	, Jr.		i	Marion	Grace	Haugla	and
a. Informant's Name/Relationshi	o (Type, Print)	19	b. Mailing	Address (Street	and Number o	r Rural Route Numl	per, City or Town, S	State, Zip Code)
Sharen Dyson/S:	ister		4818	1 Fairfi	eld Way	, Lexing	ton Park	, MD 20653
a. Method of Disposition			of Disposi	tion (Name of cem		Date	20c. Location - Ci	
Burial 2 X Cremation	3 Removal from S	tate cremat	ory or oth	er place)				
Donation 5 Other Spe		Brin	sfie]	Ld-Echols	<u>s 11</u>	/19/2010	Charlot	te Hall, MD
Signature of Funeral Service I	31/)						Home, P.A.
dward N. Brins	field, Jr.	M00052	229	955 Holly	wood R	d., Leona	rdtown,	
a. Part I. Enter the disease, or of failure. List only one cause of		the death. Do no	ot enter th	e mode of dying, s	uch as cardiac	or respiratory arre	st, shock, or heart	Approximate Interva Between Onset and
mediate Cause (Final disease	a. Contact Gunsh	ot Wound of	Head					Death
condition resulting in death)	Due to (or as a cons	sequence of):						
quentially list conditions,	b							
any, leading to immediate	Due to (or as a cons	sequence of):						
isease or injury that initiated ents resulting in death) Last	c. Due to (or as a cons	sequence of):						-
erns resulting in death) Last	d.							
UNPENDED	AMENDED							
				-			1004 D=4: -11:	in an in the second
FEMALE:	23c. If yes, outco		Ect	al death 3	Ectopic preg	nancv	23d. Date of del	Day Year
		t time of dooth		er (Specify)				, 1001
past 12 months?	own 9 Unknown		OIII			*		
		th but not resultin	g in the ur	nderlying cause gi	ven in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
past 12 months? Yes 2 No 9 Unkn	ns contributing to deat					1 Yes	2 ✔ No 3	Probably 4 Unknown
past 12 months? Yes 2 No 9 Unkn	ns contributing to dear							
past 12 months? Yes 2 No 9 Unkn	ns contributing to deat					24a. Was a	1 24b Wer	e autopsy findings available
past 12 months? Yes 2 No 9 Unkn	ns contributing to deat			-		24a. Was a	y prio	to completion of cause of
	ns contributing to deal						y prior deat	
past 12 months? Yes 2 No 9 Unkn rt II. Other significant conditio	ns contributing to deal				of Death (Chec	autops perform 1 Yes 2	y prior deat	to completion of cause of
past 12 months? Yes 2 No 9 Unkn rt II. Other significant conditio	The state of	ent 2 ER/O	utpatient	10	thos:	autops perform 1 Yes 2	y prior dear No 1	r to completion of cause of th? Yes 2 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, To the Funeral Director: completely filled in by the

OCME 2006

or Town, State) 47988 Turkey Neck Road, Lexington Park, MD (Specify) Backyard Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Signature and title of certifie 29b, 29c. License number 29d. Date signed (Month, Day, Year)

1120 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City

November 17, 2010

1 Yes 2 ✔ No

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

OCME

Pending

Investigation

Could not be

determined

Patricia Aronica-Pollak MD. Assistant Medical Examiner

Nov 16, 2010

111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year NOV 1 egistrar's Signature

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 Gerald Alfred Warren 6:08P.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Reeder's Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F June 17 174-20-8221 **1**928 Pennsylvania Director 82 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Washington County Smithsburg 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ò Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a eap. injury or other traumatic event, the Medical Examiner must be one. Funeral 9 Eckstine Ct. 2**17**83 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 ☐ No 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Power Company

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Cemetery

Physician/ Medical

GERALD

NAME: WARREN, Baltimore, Maryland

21215-0036

Examiner

Be

ည

17. Father's Name (First, Middle, Last,

20a. Method of Disposition

David Sando Warren 19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

29b. Signature and title of certifier

GHAZALA QADIR,

Phyllis I. Warren-wife

Burial 2 ☐ Cremation 3 ☐ Removal from State

attending physician and for use as the burial-transit signed by the a his certificate has bil director, page 2 sl 24 hours after death.
Funeral Director; After leted filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service Licensee	Finn	22. Name and Address of Facility Do							
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	TERMINAL M	ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. TOWN AL MEMSTATE LOUN CAMEN.							
niner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): Due to (or as a consequence of): STLOCLE	IC SYMDROME			WEEKS				
dical Exar	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of):				YEAMS.				
Completed by Physician/Medical Examiner	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delive time of the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown									
ted by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									
Complet				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of s 2 2 No				
Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Che							
<u>ا</u>	1 Yes 2 No	1 Inpatient 2 ER/Outpa	atient 3 L DOA 4 Nursing	Home 5 Residence		sify)				
ficate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) inju		28d. Describe how inju	ury occurred					
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State)							
Medical Certificate:	29a. Certifier (Check only one) 1									

29c. License number

20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11-24-2010

Eckstine Ct. Smithsburg, MD 21783

Thelma Mabel Wilson Warren

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

2010

301-432-8470

Nov

Smithsburg, Maryland

DHMH 17 Rev 7/2009

State Registrar

within 2.

To the F
complet

3H-5+1

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MARY ELIZABETH WILSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** lata Jarles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-15-1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours OHIO 268-42-6068 97 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD. CHARLES WELCOME 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20693 8285 DASHING PLACE U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify:WHITE 1 □Yes 2 🛣No Specify: 9 3 Widowed 4 Divorced natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OMN HOME 12th permit, Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be D.D.DAUGHTREY PEARL REDDING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA DAVID-DAUGHTER 8285 DASHING PL. WELCOME, MD. 20693 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State MARTINSVILLE IOOF CEM. 12-1-10 MARTINSVILLE, OHIO 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23 Part 1. Enter the disease, or complic thins that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se puentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-tran and Due to (or as a Box 68760. physician Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has Division of Vital 1 ☐Yes 2 ☐No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗔 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER Year Day Physician/ 7:10 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITTAL AGNES 8. Date of Birth (Month, Day, Ye. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) Funeral 1 №M 2 □ F 54 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 1 🗌 Yes 2 🗹 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Nu Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROOTS DR. CLENBURNIE, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, MD. 12-6-10 21. Signat/Je DOON MOUNTAIN RO. Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, 23a. Part 1. Enter the dise Immediate Cause (Final GRAM Physician/ NEGATIVE SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if they leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 2 ☐ No 3 ☐ Probably 4 X Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a. Was an autopsy perform safter death.

Director: After this certificate! To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 \square Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) DECEMBER D0070917 (0) MI 2aD SUITE LLIO - 3455 WILICENS AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLANDEEP BALTIMORE, MARYLAND 31. Date filed (Month, Da

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEPHEN A WEAVER 15:45 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOME ISE Rail Road mecmen Allegany If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year, Days Hours 213 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Lonaconing Maryland Allegany 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 15 East Railroad Street 21539 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 Laborer Paper 0 Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Monzel Weaver Edna Van Meter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Lou Hardman - Fiance 15 East Railroad Street, Midland, Maryland, 21542 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November November 1 Burial 2 Cremation 3 Removal from State Rocky Gap Veterans Cemetery 17, 2010 Flintstone, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ hreat cance Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Character at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the a ld be detached f 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗌 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Division Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animals death and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 40065 Muchie Kenneder D 11-12-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumbuland Kelly 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Month Physician/ Elizabeth Katherine Williams 2010 0735 Novembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Dalisbury Rehabilitation & N ursing isburg If Under 1 Year | If Under 24 Ars Social Security Number 7. Age (In yfs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 1 🗆 M 2 🛣 F Months Days Hours Min 04/08/193 77 217-30-8688 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Ave. 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 名しえるbeth Williar Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Hygiene the bookkeeper bookkeeping traumatic event, Be led 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o ပ permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked Frances Marie Bower Walter Kendall Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 E. Lillian St., Hebron, MD 21830 John H. Williams/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Burial 2X Cremation 3 Removal from State injury (11/09/2010 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD signature of Funeral Service License HolTowaydruneral Home Professional Association È 501 Snow Hill Rd., Salisbury, MD 21804 Domporto CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Retween Onset and Death Immediate Cause (Final Physician/ 200 disease or condition resulting in death) 000-Medical Due-to (or as a con-Examiner PR. Sequentially list conditions, if any leading cause. Enter Underlying Examine Due to or as a conse uence of or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Yes been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an s certificate has b director, page 2 s prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death Theck only one) Be examiner? Hospital 2 9 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID Robins 32. Registrar's Signature State FU Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Day Year Mary Louise Wall 4:15 AM Medical 10 2010 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Hospice 7. Age (In yrs. last birthday) If Under 14 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 579-30-4254 West'y) Virginia 0571871927 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Wicomico Hebron 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 27042 S. Tourmaline Drive 21830 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or δ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be ijury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burton Eugene Crumrine, Sr. Ada Robertson should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 27042 S. Tourmaline Dr., Hebron, MD 21830 19a. Informant's Name/Relationship (Type, Print) Cecil H. Wall/spouse Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Salisbury Crematory 11/11/2010 4 Donation 5 Other (Specify) Salisbury, MD permit.
Departi Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompool CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ DAMBN TIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner YOPA THY Drom Sequentially list conditions. Examine If at y, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 points?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 s autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.

Funeral Director: After this leted filled in by the funeral of 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 410 30. Name and address of person who completed cause of death (Item_23a) (Type, Print) 20 2

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 7:18 Αм Webster Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Ε. Vine Street 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Yes Maryland **Director** 215-20-1446 86 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director Examiner must be notified at 1 X Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21804 330 E. Vine Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "t (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Broughton White Esther Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vine Street, Salisbury, Maryland 21804 330 E. Polly Ann White - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 11-10-2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 21. Signature of Funeral Service License 22. Name and Address of Facility Bounds Funeral Home Main Street, Salisbury, Maryland 21804 23a. Pagt 1. Enter the disease, or compusions, or heart fallure. List only one is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes ျှ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State un

Registrar

10-08802 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lynette Denise Yeager State of Maryland / Department of Health and Mental Hygiene 010 38154 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 16, 2010 eager D, Medical Examiner Lynette 2100 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10304 West Ridge Drive Bowie Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) CA Months Days Director 562-45-846 1 M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Bonie Prince Georges permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygöric.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified as once Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Ridge 20721 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Klack 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) book Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UNKNOWN Be 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Jewels dir. tagram 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Suitland, MD Hill Cem e car Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensies Dridgen Muuu 9013 annapolis Rd Lam ham, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Cardiac arrhythmia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Cardiomegaly with biventricular dilatation Sequentially list conditions, Examiner if any, leading to immediate cause, Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Lest Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical s attending physician a for use as the burial -~X UNPENDED AMENDED PI line a-b, PII,27, per ME g911 1/11/11/TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Chronic lung disease 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 Other's Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural within 24 hours after death.

To the Funeral Director;
completely filled in by the f Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001 OCME 2006

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 17, 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

Melissa Brassell, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Steven Douglas Bates DECEMBER 02 2010 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOW SON SAINT JOSEPH MEDICAL CONTER Social Security Number 9. Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday If Under 1 Year 8 Date of Birth **X**X M 2 □ F (Month, Day, Year) OV. 25. 1962 302-68-9525 Director 48 Nov. Ohio Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10313-C Malcolm Circle 21030 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ρ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Diamond Comics other t Writer Be 17. Father's Name (First, Middle, Last) Should be file. I and Mental H 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic. Everett Earl Bates Laura Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Bates Wife 10313-C Malcolm Circle, Cockeysville, MD 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/03/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of FacilityCremation Society of Maryland Inc 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician MALIGNANCY METASTATIC disease or condition resulting in death) Medical Examiner SEPSIS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the at Id be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy eral Director; After this certificate filled in by the funeral director, pag Yes 2 N 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA

Date of injury 28b. Time of 1286 1 ☐ Yes 2 X No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury work?
1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral II

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the 3 Certifying Nurse Prage ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number D 46356

Registrar
DHMH 17 Rev 7/2009

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KHOSKOW

OSLER DRIVE

TOWSON, MARYLAND

d address of person who empleted cause of death (Item 23a) (Type, Print)

MD. 7601

3. Registrar's Signature

TABASSI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Duin 2000 85 nanna Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 2934 Rt. 97 Glenwood Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Hours **Director** 229-07-0152 95 <u>June</u> Virginia Usual Residence of Decedent fshow ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits MD Howard 1 🗆 Yes 2 🎇 No Glenwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2934 Rt. 21738 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 □ Divorced Completed Specify: Year or Dates. White injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Fisher Ella Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June E. Howes, daughter 12701 Woodsboro Pike Keymar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 12/07/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Sers 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Under Jing Cause (Disease or iinjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant g ☐ Unknown Yes been signed by the should be detached a \square Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of cate has b autopsy perform death? After this certificate funeral director, pag Yes 2 No □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မှု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident 1 Yes 2 No Investigation after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 24 hc

To the Fune

completed 1

State Registrar only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

32. Registrar's Signature

29c. License number

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances Thelma December Brooks 2010 9:30 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2406 Crest Road N/A Ba<u>ltimore</u> 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland Funeral Months Hours Min. 1 □ M 2 😾 F Director 212-05-9991 Yrs 96 1914 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Attrit if item 27 is marked other than "natural", or items 23a or 28a-f sho tury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2406 Crest Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 years Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard Η. Brooks Ellen Μ. Ormond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas O. Blair (son) 6057 Lexington Park Orlando, Florida 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 12-10-10 Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probabiy 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗖 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar (harus

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32. Regis

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State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13:55 Walter Joseph Beggs, Sr. 2010^{ea} Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford County 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 X M 2 □ F 213-52-2164 62 Director Marvland 1948 May Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Harford County Jarrettsville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 3740 Norrisville Road United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving and 2 should be filed within 7. Health and Mental Hygiene. em 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician Grounds 12 2 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Plecker Beggs Bessie Jean Tharp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trauonce. Sandal Lee Beggs (Wife) 3740 Norrisville Road, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Evans Funeral Chapel 12/5/2010 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive, Forest Hill, Maryland 21050 Lean of Jen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Deat Immediate Cause (Final Physician/ disease or condition minute Medical resulting in death) Examiner unknown Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of attending physician and for use as the burial-transit abotes Months Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown . Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗆 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper orla Janson m. 31. Date filed (Month, Day, Year, State **DEC 07** 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Bass sciemoex Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** University of mary knd Baltmore Medical Cente 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Min. 1 ☑M 2 🗆 F Hours Director 347-12-7438 october 9. Illimis Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🎦 No Maryland Harford Belcamp 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 23a Funeral 4800 Water Park Dr. Unit D 21017 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 1941-1945 Year or Dates. "natural" 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) President Mid-America Co. Inc. Telecomunications traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ J.E. Bass Florence Daskal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mrs. Catherine T. Bass (Spouse) 4800 Water Park Dr. Unit D, Belcamp, Maryland 21017 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20h Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott Dec. 2. ___2010 Evans Funeral Chapel Bel - Air 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Charel & Cremation Services — 3 Newport Drive Forest Hill, Maryland 21050 Jeffrey R. Testerman (M01543) 23a. Part . E fair the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. Intracrenial Hemorrhade NECKTON APPROVED BY MEDICAL EXAMINER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 2 🗆 No 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After t work? 1 ☐ Yes 2 🗖 No Fall Z/2 dizziness 1 Natural 2 Accident 5 Pending 11/29/10 Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Availan Bulkry of Elm Road, & thing determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сопріете Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier NP1 1447419247 November 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREET BATIMORE, 5 21201 22 KEVIN M. JONES GREENE

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{Year} Joann M. Buza 4:20 P 4, December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F July 1, 1944 Maryland 217-40-0767 66 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f st e notified a MD **Baltimore** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 2502 Cider Mill Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates er than "nature, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene.
ad other tha Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Baltimore County Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked of jury or other traumatic ever ပ John Buza Helen Obniski 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Laura Sue Swam/ Friend 2501 Cider Mill Road, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott December 1 Burial 2 Cremation 3 Removal from State Holly Hill Memorial 8, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Im ediate Cause (Final disc ase or condition regulting in death) Onset and Death METASTATIC PANCREATIC Physician/ Medical Examiner Sequentially list conditions if any tracing to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and de detached for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 month Day Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be DIABOTOS MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? this certificate To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Programment of the Funeral Programment o Yes 2 No 1 Tes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Street (Specify) 1 OSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name 61 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death uture (are tomore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 №M 2 □ F Months Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside Çity Limits 10c. City, Town or Location Director 1 Yes 2 No uary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Kamsa US 26 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 1ac 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Wechanic 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/S College (1-4 or 5+) econday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number of 19a, Informant's Name/Relationship (Type, Print) -tamper-20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Mt. Zion 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a conseque Examiner Securation list ou ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 2 1 1 Yes 25. Was case referred to medica examiner?

1 Yes 2 No Be completed filled in by the funeral director, 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Sign

10-09314 Bonita D. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Domita D. Diowi		1- For State Certificate of De Registrar Certificate of De			2016 g. No.	3816
Physici Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month December)	3. Time of Death 0935 hrs
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		2043 Jubilee Court Ba	Itimore		NA	
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/ any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
land f show	ō	Maryland N/A Baltimo	re			1 XYes 2 No
e Mary or 28a-	irec		Zip Code	[g. Citizen of What Cou	•
r death with the Maryland or items 23a or 28a-f show any must be notified at once,	Funeral Director		2/2/4 edent of Hispanic Origin?(Unifed -	ican Indian, Black,
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21215-0036 and be filed within 72 Mental Hygiene. marked other than c event, the Medical	ပ္ပိ	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
212 212 ould be Menta marko	To Be	Milton Spriggs, Sv, 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	Ma v	Rural Route Numb	955 er, City or Town, State	. Zip Code)
MD and 2 sho alth and m 27 is		Patricia Long-Sister 19053				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition (N				
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Balti permit Departm Imports injury o		1 Burial 2 Cremation 3 Removal from State crematory or other plan 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name a 23a Part Enter the disease or complications that raysed the death. Do not enter the more	nd Address of Facility	-114ms	F.S. P.H	2.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	e of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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No. of the state o		or condition resulting in death) Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause		_		
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5876 ertificat ding ph		23b. Was decedent pregnant in the past 12 months?	th 3 Ectopic pregn	nancy	23d. Date of delivery Month D	ay Year
Box 687 death certific.	/sici	1 Yes 2 ✓ No 9 Unknown 9 Unknown 9 Unknown	pecify)			
ch trhe	, Physic	Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
S, P.(uires than	e by	Chronic Renal Disease; Asthma		1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
ords aw requir	pet			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	Completed			perform 1 Yes 2		2 No
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Divising the state of the state	틟	3 Suicide 6 Could not be determined	ry, office building, etc.	or Town, Stat	eet and Number or Rur	al Route Number, City
E G D		4 Homicide (Specify) Bathtub 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at till	the time, date and place, and	L	ourt, Baltimore, MD	d
To the How within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in r				
	Ž		9c. License number	1.	29d. Date signed (Mon	
		(Caracau)	O.C.M.E.		December 5, 201	U
)		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 212	201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	and show i at	or	10a. State 10b. County		10c. City, To	wn or Loc	ation					10	d. Inside City Limit	S
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030	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Xidowed 4 Divorced	Armed Forces? 1 Yes 2 Hes 1 Yes, Give Year or Dates.	No	If	Yes, specify Cuba ☐ Yes 2 🛣 No	an, Mexican, Pue	erto Rican, etc.)		Black,	White, et	tc.	
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baitimor	permit. Page 1 Department of Important: If i any injury or conce.		4 Donation 5 Other (Special 21. Signature of Funeral Service Licen	*	Main		<u>Park</u>		02/10 wn Jr. Ave.,Ba		timo: eral			
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DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗀 Fetal dea		Ectopic pregnand Other (specify)	ру			23d. Date o Month		y Day Year	
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DIVISION OF	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, stree	et, factory, office		28f. Location (City or To			r Rural F	Route Number,	
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			Marjam Ke				<u> 1472</u>	4389	16,13	/1/	2411	0	 -	
-)			30. Name and address of person who Mar-Jam Kesh		eath (Item 23a)	i (lype, Pr	ol Univ	. park	wery, B	altir	nore	, M	0 21218	P
	Stat	е	31. Date filed (Month, Day, Year) DEC 0 7 2010		r's Signature	,			· ·					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 1, 2010 Physician/ 9:25 A M Gloria Μ. Bianchi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care-Potomac Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 X F Months Days Hours December 14, 1922 Washington, D.C. 579-22-2919 87 Director Usual Residence of Decedent 10a. State within 72 hours after death with the Maryland Ħ 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 X Yes 2 □ No Maryland Chevy Chase Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5480 Wisconsin Avenue, Apt. 1128 20815 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Bianchi Sira Donati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 Brookside Drive, Chevy Chase, Maryland 20815 Benjamin E. Porto / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Dec. Montgomery Crematorium, Inc. 2010 Bethesda, Maryland injury 4 Donation 5 Qther (Specify) Signature of Funeral Service Lie Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. lette Dougak any M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of neat failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ DOVAN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy has certificate 1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 읻 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 5 Pending work 1 Tes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 Sunitha Bhogavilli 9801 Georgia Avenu SILVETISPRING モルオ

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lynn Bowen Year Physician/ Month Jeri 9:40PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbur astal Hospice At the 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 45 Hours 220-86-8980 Director Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo MD Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 304 Glen Avenue, Apt. C4 21801 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", White 3 🛮 Widowed 4 🗆 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alfred Roth Janet Pusey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Westley Son 11450 Pine Pole Road, Princess Anne, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Md Final Journey Crem. 12/9/2010 21. Signature of Funeral Service License Dorrota Marshall 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma with Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director name 2 should be deathered. Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 🗷 No 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Hospital Other: မ 1 🔲 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work? 2 No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 12-04-2010 29505 00. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

GREGORIO

M.

Bowen

32. Registrar's Signature

BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY MD 21801

			Please Type or Print in Bla amend #1Per PHY &7.8&18 Per FH G	ck Indelible In 911 1/14/20 Department of	k. Ensure All Copie Health and Mental Hy	es Are Legible ygiene).
			State Registrar	Certificate of		Reg. No.2 0 1 0	38166
	Physicia		1. Decedent's Name (First, Middle, Last) Richard LYNN LYNN	Butler	2. Date of D Month	Day Year	3. Time of Death
	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, c	DECEMBE or Location of Death	4c. County of Dea	
3	Funeral		UNIVERSITY OF MARYLAND MEDICAL CENT 5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Tarre a service of the service of th		
н	Director		215-72-1453 1 DM 2 DF 57 51	Yrs. Months Days	Hours Min. 8. Date of B		irthplace (State or Foreign ountry) MD
	show dat	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow				10d. Inside City Limits
	Maryl 28a-f lotifiec	Director	MD Prince George's	College	Park		1 □xYes 2 □ No
	with the 23a or st be r	eral [10e. Street and Number 9213 Dewberry Lane	10f. Zip Code	0740	10g. Citizen of What C	ountry? USA
	death v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		lispanic Orlgin? (Specify Yes or No an, Mexican, Puerto Rican, etc.)	14. Race - Am	erican Indian,
-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ x No	Specify:	Digon, Will	te, etc. Thite
215	in 72 h e. nan "n: • Medi	duc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	 Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) 	during most of working	16b. Kind of Business	s Industry
121	filed within al Hygiene. d other thai went, the N	Be C	12 2	Asset M			n Technology
ylan	should be file n and Mental H 7 is marked o raumatic eve	일	Linwood Christian Butler Jr.		18. Mother's Name (First, Middle Barbara Pu	, Maiden Surname) ISMOTE	
, Mar	and 2 shou Health and tem 27 is m			Malling Address (Street of South Cou	and Number or Rural Route Number ntry Club Road,		28712
Baltimore, Maryland 21215-0036	t. Page tment o tant: If ijury or		1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	of Disposition (Name of ery, crematory or other place Journey Cre	Date 12/8/2010	20c. Location - City or Woodbine,	
Ba	permi Depar Impol any in		21. Signature of Funeral Service Licensee Porota Marshall	22. Name and Addres	ss of Facility nd Cremation 1413, Baltim	Services	1202
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Vit.	nysicii nis cer I direct	10 B	examiner? 1 ☐ Yes 2 💢 No Hospital: 1 💢 Inpatient 2 ☐ ER/Ou	[04]		dence 6 Other (Spec	ify)
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Divis	pital or At burs after o eral Direct filled in by	ial Cert	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)		City or Tow	,	
	Io the Hospital of within 24 hours aft To the Funeral Di completed filled in	Medical	29a. Certifler (Check 2 Medical Examiner: On the best of my knowledge, only one) 1 Certifying Physician: To the best of my knowledge, only one) 1 Medical Examiner: On the basis of examination and/or only one) 1 Certifying Nurse Practioner: To the best of my knowledge, only one)	r investigation, in my opinio	n death occurred at the time date of	and place, and due to the	counce(a) and manner stated
	Nati		29b. Signature and title of certifier	29c. License		29d. Date signed (Month	n, Day, Year)
Ų	(E)	-	30. Name and address of person who completed cause of death (Item 23a) (1		36969327	DECEMBER	1 2010
	(2)		DAUED WACKER 22 SOLATH GREEN		BALTEMAR MAR	VLAND ZIZO	1
	State Registra	_	31. Date filed (Month, Day, Year) 32. Registra's Signature.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:30 DM EAD DSCAMBIL 2010 OTTMAN-L 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Randallstown Baltimore Chapel Hill, LLC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 🏋 🗆 F 217-24-4094 82 Yrs 2**-18-192**8 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 5608 Bland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: SpecifAfrican-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk Hutzler's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hezekiah Cottman Inez Jones

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

Funeral Director

Be Completed by

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after death To the Funeral Director:

	Charles Whitehead/Hu	sband	19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 5608 Bland Avenue, Baltimore, MD 21215						
-	20a. Method of Disposition	20b. PI	ace of Disposition (/	Vame of	Dat	te 200	Location - City of	or Town, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	emetery, crematory o rrison Fores	st Veterans			ings Mills		
1	21. Signature of Funeral Service Licen	isee / 1	22. Name	and Address of Fac	oility Wy Lie	Fureral H	me P.A. o	f Belto. Co.	
1 /	Mandon	W. Welle	9200]	liberty Road	i, Randa	llstown, M	211.33		
	23a. Pary 1. Enter the disease, or com- shock or heart failure. List only	plications that caused the death one cause on each line	. Do not enter the n	node of dying, such	as cardiac or	respiratory arrest,		Approximate Interval Between	
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	resulting in death)	Due to (or as a consequ	ence of):	,	,				
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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
Ä	resulting in death) Last	Due to (or as a consequ	ence of):						
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IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delive								elivery	
cia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		c pregnancy (specify)			Month	Day Year	
lys!	9 Unknown	9 Unknown							
<u>a</u>	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlyin	g cause given in Par	t I.	23e. Did tobac	o use contribute	to the cause of death?	
Completed by Physician/Medical						1 ☐ Yes	2 ₽ No 3□	Probably 4 ☐ Unknown	
ete						24a. Was an	24h Were	autonsy findings available	
Ē						autopsy performed	prior to	autopsy findings available o completion of cause of ?	
ပိ	05.94					1 ☐ Yes 2 ☑	No 1□Ye	es 2 No	
a	25. Was case referred to medical examiner?	Hospital:		Oth -	/	(Check only one)			
P.	1 Yes 2 No	1 Inpatient 2 E		DOA 4 P		e 5 Residence		pecify)	
on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how in	ijury occurred		
cati	2 Accident investigation M 1 Yes 2 No								
‡	4 Homicide determined	ory, office	28	If. Location (Stree City or Town, S	and Number or i	Rural Route Number,			
0 CAND									
Medical Certification: To Be	29a. Certifier 1 Certifying Pha (Check only 2 Medical Exam	yeiclan: To the best of my knov niner: On the basis of examinati and manner stated.	vledge, death occurr ion and/or investigat	ed at the time, date ion, in my opinion, d	and place, ar leath occurred	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)	
Me	29b. Signature and title of certifier			29c. License numbe	r	29d.	Date signed (Mo	nth, Day, Year)	
ROSSES AMERICA 3								3	

DHMH 17 Rev 1/2001

State Registrar Smith RUENUE #203 BALTIMONE MARY PAUL

30 Name and address of person who completed cause of death (item 23a) (Type, Print)

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (1,00K 9:45 am ona Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice N/A Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Month, Day, Yea 1v 5, 1960 **Director** 212-76-2784 July Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he morified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD N/A Baltimore 1 XX es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 800 Union Avenue 21211 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Independent 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry W. Eiermann, JR. June Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Eiermann (Mother) 800 Union Avenue Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 ▼X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/3/10 Glen Burnie, MD Signature of Funeral Solvice Dicen 22. Name and Address of Facility Funeral Home, Inc. 3631 Falls Road Balto. MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician IVCI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Uisease or iinjury Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 × No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 | No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ပ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

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Sonald

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20 M Medical or Locatjøn of Death give street and number) 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, .01316 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Months 1 M 2 Director Usual Residence of Decedent show 10d. Inside City/Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f sho notified at death with the Maryland Director 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō ral", or items 23a or Examiner must be Funeral OY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) evizon 0 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) Eather's Name (First, Middle, Last) ည hnni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, Himae 21216 Nortonia ames arrot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State MD lawy calti more 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee uxerae 22. Name and Address of Facility Heia Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line interval Betweer Set and Death Immediate Cause (Final disease or condition cancer Physician/ clon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death certificate has been signed by the ilrector, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation within 24 hours after deal

To the Funeral Director;
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) d title of 29b. Signature D185 son who completed cause of death (Item 23a) Type, Print) 30. 00 31. Date filed (Month, Day, Year) 32. Registra 's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(State of Maryland / Department of Health and 1- State Registrar Certificate of Death	d Mental H	ygien	nin	38170
	hysicia /Medic	al	1. Decedent's Name (First, Middle, Last) DELCETA CALLOWAY	2. Date of D Month	Death Da		3. Time of Death 5:30 AM
Fu	xamine ineral ector	er	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 4 Months Days Hours M 1 M 1 M 2 F 1 M 2 M 2		1	SINCE GEO	DRGES place (State or Foreign ntry) MAI CA
ith the Maryland	or 28e-f ehow	Olrector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ND NONTGOMERY SPRING 10f. Zip Code		10g. C	itizen of What Cou	10d. Inside City Limits 1 XYes 2 No
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	item 27 ie marked other than "natural", or iteme 23s or 28e-f ehow other traumatic event, <u>tra Madical Exorninar man be mulified at</u>	by Funeral Director	75 EAST WALKE AVE 203 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 See 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify:	(Specify Yes or Nerto Rican, etc.)		USA 14. Race - Ameri Black, White, Specify: BL	
1 21215-0036 led within 72 hours alt tyglene.	her than "natura ot, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED NURSIAL	ASSI.		Rind of Business/Ir	,
Maryland Id 2 should be file Ith and Mental Hy	umatic even	To Be	17. Father's Name (First, Middle, Last) 18. Mother's N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	-	ILBE	RT	p Code)
and and lealth	m 27 her ti		SONIA FIDDLER - DAUGHIER 75 £ WAYIE AVE 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) JAMAICA DE	"203 S Date C. 18 2016	20c. L	ocation - City or T	MD 20901 own, State
Baltimore	any inju once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 14.35 MARYLAND	CAPITOL AVE IVÉ	110; W		De 20002
/Me	ician dical niner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	nac or respiratory	arrest,		Approximate Interval Between Onset and Death
760, 7.	ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CCM13 Due to (or as a consequence of): c. A 'IV 'CV') Due to (or as a consequence of): d.				
30 8	ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4		-	23d. Date of deliv Month	rery Day Year
ALLE TO ME TO ME TITAL RECORDS, P. SIAN: The law requires that	eugi pe q	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_ 10]Yes 2		the cause of death?
DELLE TO MINISTERIES THE LEGISTICS THE LEW REQUIRES TO	tificate has tor, page 2	e Completed	25. Was case referred to medical 26 Place of D	24a. We aut per 1 Yes	topsy rformed? 2 N	prior to co	opsy findings available ompletion of cause of
Of V	E e	ation: To B	Avaminer 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing 1 Nursing 2 Accident Spending investigation No No No No No No No No No No No No No		sidence	6 □Other (Speci ury occurred	(y)
Division To the Hospital or Attending	filled in by t	al Certification;	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	City or T	own, Stai		
To the Hoi	completely filled	Medic	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated. 29b. Signature and title of certifier 29c. License number	ccurred at the time	e, date ar	ate signed (Month,	to the cause(s)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DFITNELL CUMBERBAICH 3001 HOSPIAL DR CHEV	ERLI	MA	207	% 85
F	Stat Registra		31. Date filed (Month, Day, Year) 32. Regigrar's Signature 33. Regigrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- State of Maryland / Department of Health and Mental Hygiene 25,29a per dr.,8910,12/07/2010dnb 1- State Amend Items 25,29a per dr.,8910,12/07/2010dnb Certificate of Death Reg. No. 2 0 0 38 7									
	Physicia Medic		Decedent's Name (First, Middle, Last) Robert M. Cochra	an			2. Date of Death November	Day 2010	3. Time of Death 02 : 01 M	
	Examir		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or			4c. County of De	ath	
Ī	Funeral Director		5. Social Security Number 458-78-0335 6. Sex 1 M 2 □ F 62	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 07/08/19	9. B	irthplace (State or Foreign ountry)	
-	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Loc	ation				10d. Inside City Limits	
	he Mary or 28a-f on otifie	Director	MD Anne Arundel Ann	napoli	LS 10f. Zip Code		1 10	0141	1 ☐ Yes 2 No	
	h with the ns 23a on must be	Funeral	124 Womack Drive, #427		2140	1	100	g. Citizen of What C USA	·	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	β	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No Navy If Yes, Give Year or Dates.	у ^{lf}	/as Decedent of His Yes, specify Cuban ☐ Yes 2 X No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
215-	in 72 ho e. nan "na Medic	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki life. DO	ent's Usual Occupa: ind of work done du not use retired)	uring most of work	ing	b. Kind of Busines		
d 21	filed with tal Hygien d other ti event, the	Be	17. Father's Name (First, Middle, Last)	Electr	ical Eng		e (First, Middle, Mai		L Engineering	
rylan	should be fi n and Mental ' is marked raumatic ev	오	Irad McGrady Cochran, Jr.			Betty	Jo Grisw	ell		
, Ma	sho rau						Route Number, Ci			
Baltimore,	permit. Page 1 and 2 Department of Health Important; If item 2: any injury or other t		1 Burial 2 Cremation 3 X Removal from State Cem	netery, crema	ition (Name of atory or other place, Mem. Par) !	1	c. Location - City c		
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee Victor Doda per DVI	R 22.	Name and Address	of Facility Character For	arles L.	Stevens Baltimore	Funeral Home, ,MD 21230	
	Inysician Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Institute of the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Institute of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Institute of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Institute of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Institute of the disease or condition as a condition of the disease or condition resulting in death) Due to (or as a consequence of):								
09/	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. The the Funeral Director. After this certificate has been signed by the attending plocompleted filled in by the funeral director, page 2 should be detached for use as to complete the funeral director, page 2 should be detached for use as the funeral director.	₹∣	Premark 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal driving 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
Vital Records, P.O.	requires that to been signed be should be deta	Completed by P	Part II. Other significant conditions contributing to death but not resulting to death but not resulti	ing in the und	derlying cause give	n in Part I.		2 □ No 3 □ F	o the cause of death? Probably Unknown Itopsy findings available	
Š P	The law cate has page 2	Comp	· ween pa				autopsy performed	prior to death?	completion of cause of	
Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER.	8/Outpatient	Other	e of Death (Check	only one)	- C - Ott - (Or -	-15.0	
on of	anding Phy ath. r: After thi ne funeral	Certificate: 1	27. Manner of Death 1	Bb. Time of injury	28c. Injury a work?		28d. Describe how in		Siry)	
DIVISION	tal or Atters as after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location (Street City or Town, St		ıral Route Number,	
	the Hospi in 24 hou the Funer ipleted fill	Medical	29a. Certifier (Check conly one) 1 X Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and 3 Certifying Nurse Practioner: To the best of my knowledge.	nd/or investia	ation, in my opinion.	death occurred at	the time date and ol	ace and due to the	causeo(s) and manner stated	
	o distinction		29b. Signature and title of certifier Wasp C Wase		29c. License n	6376	29d.	Date signed (Mant	h, Day, Year)	
	V		30. Name and address of person who completed cause of death (Item 23)	Medi	ical P	eyy A	math	RSMO	21401	
	Stat Registra	•	31. Date file (Month, Day, Year) 32. Registrar's Signature DEC 0 7 2010	park	1	0	U			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year REVERLY COOK CAROL 2010 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Columbia

Var Hunder 24 Hrs.

Min. Howard County General Hospital Howard 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 21 F 212-44-0871 65 01/12/1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 5320 Dorsey Hall Drive, #124 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investigator 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Κ. Cook Nellie Mae White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tahitia Martin / Daughter 7095 S. Sentinel Lane, York, e of Disposition (Name of Date PA 17403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 12/07/2010 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service Mcer 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr. Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHUCK Due to (or as a consequence of): ISCHEMIC BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CECAL VOLVULLUS Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Ledical Examine mark to retined an once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be execute 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-trar for ed by the been signed by should be detact filled in by the funeral

Division of Vital Records, P.O. Box 68760,

dical	L.	1	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊇ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
by Pr	Part II. Other significant conditions con	23e. Did tobacco use contribute to the cause of death?	
	ANEMIA	1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknowl	
Completed	ACUTE RENAL	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	
Co	ACUTE RESPUR	performed? death? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No	
Be	25. Was case referred to medical examiner?	26. Place of Death (6	Check only one)
ို	1 XYes 2 □ No	Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		d. Describe how injury occurred
Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0060169

COLUMBIA

29d. Date signed (Month, Day, Year)

2010

DEC

21044

MD

within 24 hours a

To the Funeral D

Medical

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

29b. Signature and title of certifier.

UIFUL

Mone

SU ITE DRIVE 32. Registrar's Signature

S, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year CARR 19:52 Medical DECEMBER 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 □ F (Month, Day, Year) 214-84-9195 Months Hours Min 49 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore must be notified 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4331 East Lombard Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces 1 Yes 2 No Black, White, etc Completed by 1 X Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Car Repair Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Weldon Carr Mary K. Ogg 19a. Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Carr Grierson/Sister 621/ Mallard Lane, Lothian, MD 20711 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o remetery, crematory or other place)
Final Journey Crem. 1 Burial 2X Cremation 3 Removal from State 12/7/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Porota Marshall Maryland Cremation Services PO Box 1431, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death RESPIRATORY FAILURE disease or condition resulting in death) WEEK Due to (or as a consequence of) HEMOPTYSIS WEEK Sequentially list conditions Examiner if any leading to immed cause. Enter Underlying Cause (Disease or iinjury LUNG CANCER 2HTNOM & that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2

Physician/ Medical Examiner

28a-f show

or

23a

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"natural",

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Mental Hygiene.

Health and Nitem 27 is ma

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Baltimore, Maryland 21215-0036

use as the burial-transi signed by the attending physician and d be detached for use as the burial-trar the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

has

24 hours after death.

Funeral Director: After this certificate.

within 2

completed filled in by the funeral director,

Medical

Completed 25. Was case referred to medical Be ဂ Certificate:

examiner?

1 Yes

Manner of Death

Accident

Suicide

Natural

only one

2 No

24a. Was an autopsy ☐ Yes 26. Place of Death (Check only one) 1 N Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

	i parinpationi z 🗆	Livoutpatient	9 🗀	DOA 4	\square
5 Pending Investigation 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 Yes	2 🗆
determined	28e. Place of Injury - At ho	me, farm, stree	t, facto	ry, office	

28d. Describe how injury occurred □No 28f. Location (Street and Number or Rural Route Number,

4 Homicide building, etc. (Specify) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DECEMBER 1

9b.	Signature and title of certifier	
	122	

RES-000

29d. Date signed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BONNIE E LONZE 4940 EASTERN AVENUE BALTIMORE MD 2/224 MD PHD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC. 2010 6:15ам CARLO A. CERKO, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Min. (Month, Day, Yea September 1 X M 2 □ F Hours 89 Yrs. Director 220-07-4510 Usual Residence of Decedent 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1X Yes 2 □ No MDN/A Baltimore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 6204 Eastern Avenue S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 X Widowed 4 Divorced Specify: Completed White injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmets. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Long Shoreman Steamship Trade Assn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carlo Anthony Cerko Anna Lacardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Carney 6204 Eastern Avenue Baltimore, MD 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Most Holy Redeemer 12/4/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu Charles S. Zeiler & Son, 6224 Eastern Avenue **Baltimore** disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between shock, or heart Immediate Cause Final Onset and Death Pnysician ongcotive disease or condition Car Medical Due to (o a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? eral Director; After this certificate I filled in by the funeral director, page 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury ↑ Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. Physician/ Nathaniel Dargan, Jr. 2010 9:27 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Joseph Richey Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9, 1947 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours Min. South Carolina 63 Director 212-44-1965 May Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland Director N/A MD Brooklyn 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 3811 Saint Margaret Street 21225 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc 1 Never Married 2X Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chauffeur Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathaniel Dargan, Sr. Wilmenia MacKnight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Barbara Dargan 3811 Saint Margaret St., Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc 12/06/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service LicenseeAlyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pflysician/ Metastatic Cholangio carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 Yes 2 9 Unknown 2 🗌 No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No Yes Physician: Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other Specify CE 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending work? Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 4, 2010 Physician/ 8:45 P. M December Jacqueline Helen Dunker Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford County Jarrettsville Madonna Heritage If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Days Mary Land Hours Min. 1 M 2 7 F 83 May **Director** 214-22-2512 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 28a-f shov 10b, County 10a. State death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Pylesville 1 Yes 2 XNo Harford County Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 21132 4701 Fawn Grove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. Armed Forces 1 Never Married 2 Married 2 XNO þ Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2√√No Specify: If Yes, Give Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) N/A Elementary/Seconday (0-12) East Baltimore Guide Billing Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) မ Unknown Richard Schanaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4701 Fawn Grove Road, Pylesville, Maryland 21132 Herman A. Dunker III (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 12/07/201 Forest Hill, Maryland Evans Funeral Chapel 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee es COM Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SAR Ph_sician/ End disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical that the death certificate be Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day for Pregnant at time of death 1 Yes 2 Unknown ed by the a 9 I Inknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 3 yordsone Division of Vital Records, The law requires Completed endeme tril concu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' 1 Yes 2 No Pedo Care referred to medical hozwal 2 🚹 certificate or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ALF Hospital: 1 🗌 Yes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral injury 5 Pending work? 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 12/6/10 D31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		Н	Laurel Regio 5. Social Security Number 6.		ge (In yrs. last birthday)	If Under 1 Year	Ure If Under 24 h	Jr. 100		e George's		
	Funeral Director		230-26-5592	Sex 7. And 1 LEMM 2 □ F	84 Yrs.	Months Days			lay, Year)	Birthplace (State or Foreign Country) VA		
	d ow t	L	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo							
	arylan a-f sh fied a	Funeral Director	MD Prince	George	Laurel	cation				10d. Inside City Limits 1 □ XYes 2 □ No		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha			
		era	38 Fourth Stre	et		20707	7		USA			
		To Be Completed by Fur	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		American Indian, White, etc.		
936			1 ☐ Never Married 2xxxMarried 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 If Yes, Give Year or Dates.	1945-46	1 ☐ Yes 2XXN	o Specify:			white		
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/lan	should be fill and Mental is marked of raumatic ever		Lemmie Easter				1 .	e L. Jone	,			
Maryland			19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or Town, Stat	e, Zip Code)		
	je 1 and 2 s t of Health If item 27 or other tr		James Monroe Eas 20a. Method of Disposition	ter, Jr./S	on 155 E		Drive,		NC 27939			
Baltimore,	Page 1 nent of ant: If it ary or o		1 ☐ Burial 2¾XCremation 3 4 ☐ Donation 5 ☐ Other (Spe		e cemetery, crei	natory or other pla	i -	ecember	20c. Location - Ci			
altir	permit. Page Department Important: any injury o	P	21. Signature of Funeral Service Lice		West Arur	Name and Addre		, 2010	Odenton,	MD Home, P.A.		
Ä	permit Depar Impor any in	. 13	> Ken Skiles	M					MD 20707			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	nplications that cause one cause on each lin	ed the death. Do not ent ne.	er the mode of dy	ng, such as card	liac or respiratory a	rrest,	Approximate Interval Between		
	h sician/ Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Cardio - Pulmonary Arrest Onset and Death									
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Box 68760	ificate ig phy as the	Medi	IF FEMALE:	- d								
9 ×	ath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3		су		23d. Date of			
Bo	the at	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death 5	Other (specify)			Month	Day Year		
P.0.	es that the des signed by the a be detached f		Part II. Other significant conditions	contributing to death I	but not resulting in the u	ınderlying cause g	iven in Part I.	23e. Did t	tobacco use contribu	te to the cause of death?		
ds,	quires en sign	ted b	Sepsis						Yes 2 No 3 Probably 4 XUnknown			
Sepsis Anemid Sepsis Anemid								24a. Was	opsy prior to completion of cause of			
Re	r: The la icate ha r, page ?	To Be	OF Was asset of the state of th					1 🗌 Yes	ormed? dea 2 No 1 L	th? Yes 2 No		
/ital	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transi		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	:		Place of Death (C					
of/			27. Manner of Death	28a, Date of inju		28c. Inju	ry at		dence 6 Other (S	Specify)		
ion		ifica	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not		work?							
ivis	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)			eet, factory, office			ation (Street and Number or Rural Route Number, or Town, State)			
Ω	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge, death	occured at the time	e, date and place	e, and due to the ca	ause(s) and manner a	s stated.		
	tine from 24 the Fu	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	No.		29b. Signature and title of certifier	CONTTAN	29c. License number				29d. Date signed (Month, Day, Year)			
	l i		30. Name and address of person who	completed cause of	teath (Item 23a) (Tuno E		60936			r 2, 2010		
_	10+1			aurel Regio		l 7300	Van Di	isen Rd.	Laure	I, MD 20707		
	Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stuart Michel FEDDER Physician/ December 13, 2010 7:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Advonth, Pag Year 1937 Mary Tand 73 Director 578-48-1668 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location
Silver Spring 10b. County ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 S. Leisure World Blvd., #421 20906 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Year or Dates. 1960's 1 ☐ Yes 2 🙀 No Specify. white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ the Accounting Accountant permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Fedder Ethel Ruth Wender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State Zip Code 2901 S. Leisure World Bivd., #42I, Silver Spring, MI Faye Fedder, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 12/03/10 Olney, MD Signature of uneral Service Licensee ቸንትሮከተተለያዩያ፣ ዛጅ፱፻፵w Funeral Home <u>254 Carroll St., NW, Washington, DC</u> 20012 23a. Part 🔭 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 Year Physician/ Squamous Cell Cancer of Right Ear disease or condition resulting in death) Medical Examiner Weeks Status Epilepticus Sequentially list conditions, Examine rany, reading to infriedrate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Weeks Encephalopathy that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type 2 Diabetes Mellitus, Renal Transplant (1997), 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 7 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, ESM MD D 0065485 12-3-2010 suparuch 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich, M.D., 1500 Forest Glen Road, Silver Spring, MD

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

heila Faulcon		State 1- For State	e of Maryland / Depa	artment o rtificate o		Mental Hy		2016	38179
Physici	an/	Registrar 1. Decedent's Name (First, Middle,La		tinoato o	Dodan		2. Date of Dea		3. Time of Death
/ledical Exami		Sheila _	Faulcon				Month Decembe	Day Year r 1, 2010	1034 hrs
		4a. Facility Name (if not institution, g Johns Hopkins Hospital	ive street and number)		4b. City, Town, or L Baltimore	ocation of Death		4c. County of Dea	th A
Funeral		· ·	Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	rth(MM/DD/YYYY) 9. B	irthplace (State or
Director		01- 100 000-1	_M 2×F 5/	Yrs	Months Days	Hours Min.	Enh 1	Fore	
		Usual Residence of Decedent			· L		VeD, &	0,11391	
* any	Director	10a. State 10b. County	10c. City,	Town or Locat	ion				10d. Inside City Limits
/ A Maryland 28a-f show		Ma. Bal	timore E	ssex	1405 7 0-1-			l0g. Citizen of What Co	1 Yes 2 No
74 名 th the Maryland 23a or 28a-f sho		10e. Street and Number	1 / 1 +		10f. Zip Code	51		log. Citizen di What Co	anay? A
with th		11. Marital Status	12. Was Decedent Ever in U	.S. 13. Wa	as Decedent of Hisp	anic Origin? (Sp	ecify Yes or No	- 14. Race - Ame	rican Indian, Black,
death v	Funeral	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 No	If Y	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc.	
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hours "natu		15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		it's Usual Occupations of working life. I			16b. Kind of Business	/Industry
36 thin 72 than than	Completed	/)	2	SP	cretar	- 1/		Stato	of Md
21215-0036 74 A wid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sh c event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, La	st)	0.0		8.Mother's Name	(First, Middle,	Maiden Surname)	<i>y</i> , 1164,
2121 uld be fil Mental I marked	Be	Herbert t	Kina Sr.	Taoh Mailin	- Address (Obs.)	ElSIE	2 Ve	Jones	a Zin Code)
MD 2 nd 2 shoul alth and M m 27 is m	욘	19a. Informant's Name/Relationship	(Type, Pri) Sisters	777h	Address (Street	and Number of N	- Route Nur	mber, City or Town, Star	2/207
imore, MD 2 Pages 1 and 2 shou ment of Health and I lant: If item 27 is n or other traumatic		20a. Method of Disposition		Place of Dispos crematory or ot	ition (Name of cem		Date	20c. Location - City of	or Town, State
MOF Pages 1 ent of 1 nt: If		1 X Burial 2 Cremation 3 4 Departion 5 Other Speci	T. Kemovai iloin state	in the	Cemete	FU 12/1	0/2010	Dunda	IK Md
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Lin	9,000	- Address	lame and Address	of Excility	in and	Hama D. D.	
		232 Part I Father the discorpe or cor	relications that caused the death	7.2	seph L.K.	rth AU	respiratory arr	to Ma! 21	Approximate Interval
Physician Walical		23a. Part I. Einer the disease, or contailure. List only one cause on	each line. Electroly a. water into			of Unkno	wn Caus	se(probable	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence o		011)				
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	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	- Due to (or as a consequence of c	, ,					
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Sox 68760 death certificate te attending phy I for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de		ital death 3 L her <i>(Specify)</i>	Ectopic pregna	ncy	Month	Day Year
Box 6876 e death certificat the attending phy ed for use as the	Physician/M	1 Yes 2 No 9 ✔ Unknow		5 [_] Ot	ner (Specify)				
P.O. BC s that the de- gned by the e	by Ph	Part II. Other significant conditions		-	ınderlying cause giv	ven in Part I.		obacco use contribute to	
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Division of Vital Records, tal or Attending Physician: The law requiring after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a page 2 should be a set of the funeral director, page 2 should be a set of the funeral director.	III	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 401 E. Eag Baltimore, Md.							tural Route Number, City Lager St.
fospitu 4 hour annera ely fill		29a. Certifier	ician: To the best of my knowled			e and place, and			
Divis To the Hospital or Avidin 24 hours after of To the Funeral Directompletely filled in by	Medical	(Check only one) 2 Medical Examin	er: On the basis of examination a and manner stated.	nd/or investiga	tion, in my opinion,	death occurred a	t the time, date	and place, and due to	he cause(s)
E 3 E 8	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (M	
		mesa			O.C.M	1.E.		December 4, 20	J1U
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure			· ·		
	_	TIEC A # 2010 /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FOUNTAIN **Physician** TAMLEY DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner BALTIMORE MEDICAL CENTER BAYYIEW JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-62-5404 Days 1 □ M 2 □ F Director Dec.18,1954 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show Department of Health and Mental Hygiens (** Invoirs aren ueaur win the Maryla Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examinational Regional Source. N/A MD Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3817 Ravenwood Avenue 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 25 No Specify: SpecifyBlack þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 12th N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Fountain Mabel Russell ပ္ ^{19a.} Informant's Name/Relationship *(Type. Print)* Tarsha Fountain/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3817 Ravenwood Ave. Balto., MD 21213 20b. Place of Disposition (Name of Mt. cemetary, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 12/9/10 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto., MD 21223 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTRACEREBRAL MEMORRHAUE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Polsilou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner UNKNOWN law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 1XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print) AV, MFL WIGH 6MFL, BALTIMORE, MD 2004 32. Registrar's Signature

29c. License number D0070971 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ CATHERINE M. FRANKENBERGER DEC. 2010 1:10 Рм Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 4603 WHITE AVE BALTIMORE N/A5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛱 F Months Days Hours 214-01-2797 91 MAY 1224, 1919 Director MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4603 WHITE AVE 21206 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 No Specify: WHITE If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 6 Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thre any injury or other traumatic event, the 1 angles. HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FERDINAND FRANZ 2 MARY J. BECKMAN 19a Informant's Name/Relationship (Type, Print)
KATHLEEN FRANKENBERGER-DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603~WHITE~AVE~BALTIMORE, MD 21206~20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 12/6/10 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. shock, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the Approximate Interval Between , or heart fa Immediate Cause (Final Onset and Death Physician proceed disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 1 Natural iniury 5 Pending 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 7245 unese 31. Date filed (Month, Day, Year, 3. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year DJ Gilmore DECEMBER 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SINAI HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 □ F **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours Min. Director 216-32-0076 3-1935 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits GILMOR 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Koko Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🕅 Widowed 4 □ Divorced Specify: African-American Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 10th Chauffeur Be KNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Willie Gilmore Byrd Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Patterson/Daughter 2414 W. Coldspring Lane, Baltimore, MD 21215 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖰 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 1-2010 | Woodlawn, MD The Fureral Home P.A. of Balto. Co. 4 ☐ Donation 5 ☐ Other (Specify) 12-11-2010 King Memorial Park 21. Signature o Funeral Service Ligenses 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or illijury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END-STAGE RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. Ineral Director: Al 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie RES-000 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE DAVID RK MD SINAL

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

DEC 07

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Virginia Galvin 2010 12:20 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4804 Hollywood Road College Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Arlington. Director 578-05-8053 92 1918 September Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. . Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Prince George's College Park 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4804 Hollywood Road 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Meat Wrapper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Tyler Gill Agnes Helena Huseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Singleton / Daughter 4341 Coral Springs Drive, Coral Springs, FL 33065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State 12/6/2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 X No been signed by the should be detached 1 ☐ Yes ∠ ∠ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate Yes 2 X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Nother (Specify) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After iniury X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifie 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Nurse Practice of the basis of my knowledge, death occurred at the time, date and place, and the cause(s) and manner as stated. (Check within 2 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

4

State Registrar

Registrar DLG 0 7 201

7525 Greenway Center Drive, Suite #205, Greenbelt, MD

Oate filed (Forth, Pay, Year) 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

D23743

12/6/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ Mary Elizabeth Hennessey 07:27 Рм 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford County Madonna Heritage Jarrettsville Social Security Number 7. Age (In yrs. last birthday) 97 vrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🗆 M 2 🔀 F 212-01-6120 Vrs Director 10b. County filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at or 28a-f sho 10a State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Harford Forest Hill 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Wileywood Court 21050 United States of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White Specify: "natural", 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Real Estate Leasing Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Taubman Properties 9 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumotic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elsie Marie Cohee George Noakes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Wileywood Court, Forest Hill, Maryland 21050 19a. Informant's Name/Relationship (Type, Print) Joellen Esbrandt - niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dec. 8,2010 Baltimore, Maryland Baltimore Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville
8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Step nd disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or se a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of hypothywid is ~ 24a. Was an has autopsy performed death? After this certificate 1 Tyes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No I Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/6/10

State Registrar DHMH 17 Rev 7/2009 30. Name and address of person

31. Date filed Wonth, Day, Year)

Klorse

2010

Kerrencest

Who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

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Baitimore

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21266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 10:51 aм Leonard Francis Herold Dec. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster 5. Social Security Number 8. Date of Birth (Month, Day, Year)
May 19, 1929 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Maryland 81 Director 213-26-5249 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Reisterstown Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. A. 21136 624 Main Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Globe Security 12 Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Catherine Franz William Herold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, MD 21136 Mary M. Goldsmith Niece Carolstowne Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/6/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road m lepho. Reisterstown, MD 21136 ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Oi 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and defeached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day Yes 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Loknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 1 Yes Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: MOSPIC မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical fring Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier NI 29d. Date signed (Month,

5¹ State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Doris J. Holland 2010 6:01PM DECEMBUR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Levindale Hebrew Geriatric Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖼 F Months Days Hours (Month, Day, Year, 236 48 9021 Yrs. <u>Virgi</u>nia 78 Director Nov. 7, 1932 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2X No Maryland Baltimore Essex ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 1306 Old Eastern Avenue 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Completed by Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White Specify: "natural", 3 Widowed 4 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill riment of Health and Mental rtant; If item 27 is marked o မ Emma Webster Noah Snuffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Michigan Drive Reading, Pennsylvania 19608 Andrea Leonti (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 12/8/2010 Fallston, Maryland Highview Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Maryland 21221 23. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final ATHEROSCLEROAL Physician/ CARDIOVASCULLAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner riany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for an a connections of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, OBSTRUCTIVE PULMONALY DISEPASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 □ No Other: 2 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours To the Funeral Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 131136 DECEMBER 6, 2010

State Registrar

DHMH 17 Rev 7/2009

. 2434

MD

32. Registrar's Signatur

W. BRVENERE AV, BALTIMORE, NO 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 27 **Physician** 7 mar November 2010 12:50 PM /Medical Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner tomore Sattimo Hugusburg Ja. ursing tome If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, May 23 9. Birthplace (State or Foreign Country) last birthday) **Funeral** Months Days Hours Min Year! 1 □ M 2 🖫 F Director 104-12-4029 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nature". 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ■Yes 2 No more **Funeral Director** 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21208 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Newer Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) eacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Woodglen 19ce MON STher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Si pature of Funeral Service Licensee 22. Name and Address of Facility Height Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cossequence of) Physician/Medical Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, physician the as ttending IF FEMALE: or us. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the o Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by CARDIOVASCI 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending Natural 5 Pending investigation Injury 1 🗌 Yes death. hours after death uneral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 24 and manner stated. 29b. Signature and title of certifier 29d. Date signed 5010

DHMH 17 Rev 1/2001

State Registrar

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

of person who completed cau

30. Name and address

		Sector Leading Management			
rds, P.O. Box 68/60,		baltimore, maryland 21213-0036		2	
quires that the death certificate be executed	Phy /M Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Health and Mental Horiena		8	
en signed by the attending physician and uld be detached for use as the burial-transit	rsicia ledica amine	"natural", or items 23a or 28a-f show ledical Examiner must be notified at	unera	Physi /Med Exan	

			1 - For State State Registrar	Cert	ificate of l	Death	Reg.	M2.0 0	38188		
	Dhusiel		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Yea			
	Physicia /Medic		MARY HAL				December	05, 20			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Do	eath		
	and the same of the same		St. Joseph Nursing Home		Catons	ville		Baltir			
	Funeral		1□M 217 F	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)		
	Director		212-30-9622	3		Ll	01/15/19	32 I	Maryland		
	and w		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Loca	ation				10d. Inside City Limits		
	f sho	0	MD Baltimore		Catons	ville			1 ☐ Yes 2 📉 No		
	the l	Director	10e. Street and Number		10f. Zip Code	<u> </u>	10g	Citizen of What	Country?		
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	ns 23	era	1222 Tugwell Drive 11. Marital Status 12. Was Decedent Evi	er in U.S. 13. W		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,		
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21215-0036	urs a al", o	2	3 ¼V idowed 4 □ Divorced If Yes, Give Year or Dates:	1	□Yes 2□XNo	Specify:		Specify:	White		
Ş	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occup	nation during most of worki		b. Kind of Busine	ss/Industry		
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ā	2 sho		19a. Informant's Name/Relationship (Type. Print)	,		and Number or Rura		•			
	1 and Health em 27 other tr		Andrew W. Kohler (Brother)			Avenue, B		c. Location - City			
0	Pages 1 nent of Ha ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem				•			
Ē	tmen tant: jury		4□ Conation 5 ☑ Other (Specify) Entombmen			The second secon	9/2010 E	Baltimore	e, Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.		21. g atum of Funeral Service Licensee		Name and Addre				Home, Inc.		
			A2000						cyland 21229		
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death		
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4.	/Medical Examiner		resulting in death) Due to (*** s a ***)	consequence of):	- M. 244-2-11-12-1-1				J		
È	Lxammer	<u>.</u>	Sequentially list conditions, b.	currenguinos uti:							
	sit ed	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	surmerques in a copy							
	ecut and I-tran	хап	that initiated events resulting in death) Last Due to (or as a	consequence of):				+			
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Ř	atten for u	ian	in the past 12 months?	☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify) _	У		Month	Day Year		
P.O.	itcian: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	Completed by Physician/N	1 Yes 2 No 9 Unknown		- 11.0. (5) - 0.0.7/ _						
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g	n: T ficate or, pa	င္ပ	25. Was case referred to medical			26 Place of Don't	1 Yes 2 h (Check only one)	No 1LI	res 2 No		
5	Physician: r this certifica ral director, p	m	examiner?	t 2 ☐ ER/Outpatient	3DI DOA Oth		me 5 Residen	oo 6 DOthor (Propify)		
o	Phy r this eral d	5:	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Inju Wo		28d. Describe how		эреспу/		
O	Attending F r death. ector: After by the funera	tion	1 Accident 5 Pending (Month, Day	Year) Injury		rk?]Yes 2∐No					
Division or Vital Records,	Atten deat sctor	fica	3 Suicide 6 Could not be 28e. Place of injury	y - At home, farm, stre	et, factory, office				r Rural Route Number,		
2	after after Dire	Certification:	4 ☐ Homicide determined building, etc.	(Specify)			City or Town,	Stare)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of e and manner state	examination and/or inv							
	ithin o the	Mec	29b. Signature and title of certifier 2		29c. Licens	se number	290	l. Date signed (M	lonth, Day, Year)		
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•			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type	Print)	1 1 1 1		-cur-,			
			30. Name and address of person who completed cause of des	m 901	124.1	For A	enue B	11/	W L1230		
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar	's Signature							
	Regist		DEC 0 7 2010	A be	es.						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2010 Month Physician/ James Samuel Harris 430 A NOV. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG Forest Ville N/H Forestville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 ₹ M 2 □ F 578-28-6355 Director Feb. 1925 PA 85 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Medical Examiner must be notified at **Funeral Director** D.C. N/A Washington Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9 23a 5223 Forth 20011 USA St. N.E. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ild be filed within 72 hours after a Mental Hygiene. harked other than "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kane Transfer other traumatic event, the Truck Driver N/ABe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Daisy Randolph James Harris permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Anthony Harris-Bey/Son 13 Harbor Tree Ct. Montgomery Village, MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place)
Final Journey 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/4/10 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charisse N Woods 2700 Edmondson Ave. Balto.,MD 21223 23al prt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MUCHOSCLEROSTE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordening Cause (Disease or iinjury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical E Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate be to a funeral Director: After this certificate be to a funeral Director. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ALZHEIMEN'S DISPESSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYODELO MIS M autopsy 1 ☐ Yes 2 ☑ No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI NE CUISHIMOTEN 60 VALVUN

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RICHARD 12:30 A JAY HAPPTCK DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JACOB'S WELL ASSISTED LIVING BEL AIR HARFORD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. July 1 Country) Director 096-12-7182 New York 88 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han material. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2411 Spring Valley Drive 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1X Yes 2 \(\square\) No Black, White, etc. Completed by 1 \square Never Married 2 \square Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Adam Happick Mildred (nmn) Everhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2411 Spring Valley Drive, Bel Air, Maryland 21015 John R. Happick / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Bugal 2 Quernation 4 Donation 5 Dother cemetery, crematory or other place Other (Specify) Arlington, Virginia Arlington Nat'l Cem. 12/27/2010 re of Fun 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. W. Broadway, Bel Air, Maryland 21014 23a Part 1. Enter the disease, or complications shock, or heart failure. List only one cause disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown a \ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has autopsy perform page 2 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Spe Hospital: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending after death Director: / Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Name and

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici		Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Dea		3. Time of Death
Andical Exami		Elizabeth Jean Hartman					Month Decembe	Day Year r 1, 2010	0225 hrs
		4a. Facility Name (if not institution, give street and number	er)	4		r Location of Dea	ath	4c. County of Deat	th
r0* 		Upper Chesapeake Medical Center		A 1.1-11- d = . 3	Bel Air	Lwu, 6 <i>i</i> i	I	Harford	idh-l (Chaha an
Funeral Director		218-26-8992 1 M 2 F	Age (In yrs. la:	Yrs.	If Under 1 Ye Months Da		in. Aug.	15, 1929	
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Location	on				10d. Inside City Limits
8		Maryland Harford	To	nna					1 Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number	1 00	ppa	10f. Zip Code		1	0g. Citizen of What Cou	untry?
th the Maryland 23a nr 28a-f she notified at ooce	ä	538 B Riviera Drive			21085	5		USA	
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a nr 28a-f sherrammatic event, the Medical Examiner must be notified at socc	uneral	11. Marital Status 12. Was Decede 1 Never Married 2 V Married Armed Force				ispanic Origin? (an, Mexican, Puer	Specify Yes or No	14. Race - Ame White, etc.	rican Indian, Black,
or ite	핊	1 Yes	2X No				to ribari, etc.)		
rs afte ural",	<u>\$</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or	ompleted)		Yes 2 X N	o specify: ation (Give kind o	of work done	Specify: Whi	,
2 hou	ompleted	Elementary/Secondary (0-12) College (1-4 o				e. DO NOT use r		l services	
036 ithin 7 ithin 7 reference	흽	12		Offic	e Assis	stant		Federal	Government
, MD 21215-0036 and 2 should be filed within 72 he feath and Mental Hygiene. tem 27 is marked other than "na trammatic event, the Medical Ex	O	17. Father's Name (First, Middle, Last)	·					Maiden Surname)	
121 Id be i Aental	BB	John Espa Clawson 19a. Informant's Name/Relationship (Type, Print)		19h Mailing	Address (Stre	Kathe:	rine Vir	ginia Mohr mber, City or Town, Stat	e Zin Code)
MD 2 d 2 shou lith and P n 27 is r	٢	John Muhlbaier / Husband		_				, Maryland,	
6, N 1 and Health item		20a. Method of Disposition			tion (Name of c		Date	20c. Location - City o	r Town, State
more Pages 1 nent of H ant: If it		1 XBurial 2 Cremation 3 Removal from 9 4 Donation 5 Other Specify:	J. ale		.'s Ceme	tery 1	2/4/2010	Fullerton,	Maryland
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mec		21. Signature of Fuffelal Service Licensee	-4-		ame and Addres	ss of Facility	McComas 1	Funeral Hom	e, P.A.
		/ Land / / / 5	70	13	17 Coke	sbury R	oad, Abi	ngdon, Mary	land 21009
Physician Medical		3a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.					or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
xaminerغر	ĺ	Immediate Cause (Final disease or condition resulting in death) Hypertensive A Due to (or as a condition resulting in death)			ovascular D	isease			Death
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	ner	if any, leading to immediate Due to (or as a concause, poter underlying cause	sequence of)						
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fox 68760, eath certificate be executed a strending physician and for use as the burial - transit	Medical	UNPENDED							_
876(ificate ig phys	Ž	IF FEMALE: 23b. Was decedent pregnant in the	ome of pregna		al death 3	Ectopic preg	nancv	23d. Date of delive Month	ry Day Year
X 68 th cert ttendin r use a	sician/	past 12 months?	at time of dea	- =	er (Specify)			2010	, , , , ,
Bo he dear	Phys	1 Yes 2 No 9 Unknown 9 Unknown					100- P:41	obacco use contribute to	M
, P.O. res that th signed by be detach	J.	Part II. Other significant conditions contributing to dea multiple rib fractures due to fall, chronic		-		given in Part I.	1	s 2 No 3 Pro	
ords, wequires is been signification of the state of the	Completed	moniple his mactores due to fail, dimonic	ODSTIOOTIV	e poimonai	y discuse		24a. Was		utopsy findings available
law ro	ng L							rmed? death?	completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical			26 Plac	e of Death (Chec		2 ✓ No 1 Y	es 2 No
/ital	Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpar	tient 2 I	ER/Outpatient		John -		Residence 6 Othe	er:
ding Phy. After th	은	27. Manner of Death 28a. Date of Ir	njury	28b. Time of In	jury 28c. Inj	ury at Work?		how injury occurred	
ion trendia leath. tor:	atio	1 Natural 5 Pending Nov 17, 20 Accident Investigation	100017	UNKNOWN	1 🗆	Yes 2 ✓ No	Subject fell		
ivis lor At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of			t, factory, office	building, etc.	or Town, S	State)	ural Route Number, City
Spital hours meral y filled		4 Homicide determined (Specify) M 29a. Certifier 1 Certified Physicians To the best of					538 Riviera D	Prive, Unit B, Joppa ,	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of ex	amination an						
To With	Med	29b. Signature and title of certifier	d		29c. Licer	se number		29d. Date signed (Mo	onth, Day, Year)
		Mala Bar Ol			0.0	.M.E.		December 1, 20	010
8		30. Name and address of person who completed cause of	f death (Item 2	23a)					
		Melissa Brassell, MD Assistant Medic			enn Street,	Baltimore, M	D 21201		
S: Regis		31. Date filed (Month, Day, Year) 32. Regist	rar's Signatur	Red					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER HARRIETTE DRUMMOND HERRMAN 2010 7:55 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 101 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🗓 F Hours May 1909 Washington, DC 217-54-9179 Director Usual Residence of Decedent 28a-f shov ä 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Examiner must be notified 1 🗆 Yes 2 🏝 No Maryland Harford Bel Air þ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1317 Locust Ave. USA 21014 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 → No Specify. "natural", 3√ Widowed 4 □ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " went, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. Page 1 and 2 should be ment of Health and Menta Joseph J. Minson Sarah M. Goodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Boggs / Daughter 1317 Locust Ave., Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition

1 Buriai 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Donation Donation Donation Licenses Pulper of Funeral Service Licenses 4 ☐ Donation 5 ☐ Other (Specify) Tabor U.M. Cem. 12-8-10 Mt. Bel Air, Marvland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): deweil disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Sirth Pregnant at time of death in the past 12 months? Dav Year the 9 Unknown 9 Unknown n signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? hours after death.

uneral Director: After this certificate has a filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) To the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032256 December (,20,0

Registrar

DHMH 17 Rev 7/2009

State

DAVID

DUNN

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Departmen Certificate		and Me		2.0		391	03
_			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	e or Death	—Т	2. Date of Deat	leg. No	1 1/	001	70
	Physicia	n/						er ^{Day} , 2	o Year	3. Time of 6:00	P M
	Medic		Abelardo Hernando 4a. Facility Name (if not institution, give street and number)		Town and another a		Decembe	T		0.00	I (V)
	Examin	er			Town, or Location of Rockvill			4c. Count	y of Death L tgom e	* ***	
			Montgomery Hospice Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last bit				3. Date of Birth		, —	olace (State or	Foreign
	Funeral Director		025-58-6985 1 \(\times \) M 2 \(\times \) F 62	Yrs. Months	Days Hours	Min.	Month, Day,		Quan	try) entina	roreign
			Usual Residence of Decedent			<u> </u>	may J,	1740	111-6	2116 2116	
	and show	ō	10a. State 10b. County 10c. City, Tow	wn or Location					1	0d. Inside Cit	y Limits
	laryk 3a-f :	ect	Maryland Montgomery		Potomac					1 🗌 Yes	2 X No
	or 28	급	10e. Street and Number	10f. Zip				10g. Citizen of	What Cour	ntry?	
	with 1 23a 1st b	eral	10923 Bells Ridge Drive		20854	}		United	Stat	es	
	eath tems er mu	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decec	lent of Hispanic On	gin? (Specif	fy Yes or No-	14. Ra	ce - Americ	an Indian,	
9	or it	by F	Armed Forces? 1 □ Never Married 2 🗓 Married 1 □ Yes 2 🖾 No		rify Cuban, Mexican				ck, White,		
<u>ლ</u>	rs afi ıral", IExa	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 X Yes	2 ☐ No Specify:	Argen	ntinian	. Specify	· Wh	ite	
ה	hou "natu dica	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	ia. Decedent's Usua	al Occupation	t of working		16b. Kind of E	Business Inc	dustry	
7	in 72 ie. han '	E O	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use	retired)	t or working	- 1	_	_		
7	i with ygien her t t, th		5+	Prof	essor			Georget	cown l	Jnivers	sity
ב	be filed within 72 hours after death with the Maryland kendal Hygiene kend at Hygiene and a maturall", or items 23a or 28a-f sho foevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		18. Moth			Aaiden Surnam	·		
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Montal Hygene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at		Esteban Hernando				Enriqu	eta Lar	nda		
Ja	au is			9b. Mailing Address							.
<u>~</u>	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr			10923 Bel		Drive					*
Baltimore,	e 1 a t of H If ite or oth			of Disposition (Nan tery, crematory or o	ne of ther place)	Decembe Decembe	te r 3.	20c. Location	- City or To	own, State	
Ē	ment tant:		4 ☐ Donation 5 ☐ Other (Specify) Montgot	mery Cremat	orium,Inc	201	ō , l	Bethesd	a, Ma	ryland	
Sall	eparti nport ny inj nce.		21. Signature of Funeral Service Licensee	Robert A	d Address of Facilit L. Pumphrey Sconsin Aver	^t Funera	1 Home/B	ethesda-	Chevy,	Chase, I	nc.
<u>n</u>	10 m = 0 0		M01360	7557 Wis	sconsin Aver	nue, Be	thesda,	Maryland	20814	- 3501	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mod	e of dying, such as	cardiac or r	espiratory arre	est,		Approximate Interval Betv	
	hysician/	0.3	Immediate Cause (Final disease or conditionaLung Cancer	r with Me	tactaces					Onset and D	
ز	Medical		resulting in death) a. Due to (or as a consequence		cascases						
	Examiner	L	Sequentially list conditions								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	e of):						:	
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189	tifica ng pl	Physician/Med	IF FEMALE:								
o ×	h cer tendi r use		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea	ath 3 🗆 Ectopic	oregnancy				ate of deliv		
Rox	deat he at ed fo		1 Yes 2 No 4 Pregnant at time of death 9 Unknown	pecify)			M	onth	Day Y	ear	
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J.	s the ignec be de	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting	J in the underlying t	cause given in Fait		i	tobacco use contribute to the cause of death?			
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ě	sician: The la certificate ha lirector, page 2	Completed					perfor	med?	death?	2 🗆 No	
g	ian: ertific ctor,	Be (25. Was case referred to medical examiner?		26. Place of Dea	e of Death (Check only one)					
5	Physic this ce ral dire	2	1 Yes 2 No Hospital:	Outpatient 3 D	OA Other: 4 🗆 No	ursing Home	e 5 🗌 Reside	ence 6 🛚 Oth	ner (Specify	Hospi	ce
Division of Vital Records,	ng Pl fter tl inera	ig:	27. Manner of Death 28a. Date of injury 28b. 1 X Natural 5 ☐ Pending (Month, Day, Year)	o. Time of 2 injury	8c. Injury at work?	28	d. Describe ho	ow injury occur	red		
0	eath. or: A the fu	Ę	2 Accident Investigation	М	1 🗆 Yes 2 🗆] No					
NSI	r Att ter d irect	Certificate:	3	farm, street, factor,	, office	28	If. Location (St City or Town	treet and Numb	er or Rura	Route Numb	e <i>r</i> ,
ā	ital o Irs af ral Di lled ir					10		,/			1)
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	the I	ž	only one) 3 Certifying Nurse Practioner: To the best of my know	wledge, death occur	rred at the time, date		and due to the	cause(s) and n	nanner as st	ated.	
_	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di		29b. Signature and title of certifier	290	; License number			29d. Date signe			
	}		16 cunV		D37142		I	Decembe	r 1,	2010	
	20		30. Name and addless of person who completed cause of death (Item 23a)			37	1 1 0	2052			
			G. Coleman, M. D. 1355 Piccard		ockville,	Mary	land 20	UCOL			
	Stat Registra		31. Date filed (Month, Day, Year) OFC 0 7 2010 December 132. Registrar's Signature DFC 0 7 2010	New?							
	- region		I TIPL U L CUIU / Nambor No. 2000	*-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician JOHNSOF 2018PM 16C 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONE Agnes Balti 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 60-35 1 □ M 2 □ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, I'm Medical Experiment must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No Director Marylana More 10e Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ⋧ 3 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) School Elementary/Secondary (0-12) SVSTEM College (1-4or 5+) lechnician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Ann lor 2 19a. Informant's Name/Re ationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Morta vold permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troops. Mary 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State etro atonsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro mate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final **Physician** Acute Embolio Days /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No this certificate 2 □No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death.

he Funeral Director: After this pletely filled in by the funeral directal di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dankan M.D 12/05/2010 23612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 1/2001

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2010

31. Date filed (Month, Day, Year)

ADHIKARI

32. Registraris Signature

900 South Couton Ave.

Baltimore, 141 D-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Johnson December Lee 11: 55 PM Arthur 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore . Age (Irr yrs. last, birthday) 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 D F Months Hours (Month, Day, Director arolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) abores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည IDUNSO: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, COUSIN Ba Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, atonsville 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) UNKNOWN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Discass or imjur that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage Renai Division of Vital Records, Disease 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 No 1 Yes 25. Was case referred to medica the funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Eyasu Mekonen, m.D December 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar HMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Johnson,

parke

Boulevard

32. Registrar's Signatur

Raven

Eyasu

Baltimore

Mekonen,

MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of H			iene		38196
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h		3. Time of Death
	Physicia Medic		Dorothy L	. Jackson				Novembe	er ^D 28,	$2\overset{Year}{0}\overset{I}{1}0$	12:20A M
	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Coun	nty of Death	
			Carriage Hill B			Betheso				tgomer	
	Funeral Director		5. Social Security Number 6. S 1		i. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November 2	Xear 013		place (State or Foreign otry) ington, D.C.
			Usual Residence of Decedent		7			November 2	0,1913	Wasin	ingcon, D.C.
	shov dat	į	10a. State 10b. County	10c. (City, Town or Lo	ation				1	10d. Inside City Limits
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	h the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		
	th wit	ner	5215 West Cedar			20814				d Sta	
_	r dea		11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 🔼 No	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ace - Americ lack, White,	
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Albert Wilson				18. Mother's Nam		faiden Surnai	ne)	
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saltimore,	permit. Page 1 a Department of H Important; If ite any injury or ot		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State M	ontgome:	natory or other plac	Decer 201	nber 3,		-	
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<u> </u>	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	☐ ER/Outpatier	Oth	er:	ome 5 🗆 Reside	ence 6 🗆 O	ther (Specifi	v)
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Division	or Att	Certificate:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (St City or Town		nber or Rura	l Route Number,
בֿ	pital ours a eral C		29a. Certifier 1 🔀 Certifying Phy	sician: To the best of my kno	awledge deeth	occured at the time-	date and place	od due to the acco	sale) and	nner ee etct	ad.
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	iner: On the basis of examina se Practioner: To the bast of	tion and/or inves	tigation, in my opinio	on, death occurred a	t the time, date an	d place, and	due to the ca	ause(s) and manner stated.
	To the within To the	2	29b. Signature and title of certifier	A 1	, idiowiouge, i	29c. License			29d. Date sign		
			1 MARY	Wednest		D1765	56		11/29	7/2010	
	15		30. Name and address of person who	completed cause of death (It	em 23a) (Type, F	Print)		15 Da+h-			
	1~		Tip Woodward, M			DBOX 11WU	purce c-	1) Derlie	sud, I	iai y id	
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DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Brooks Jeffries Physician/ 2010 11:12 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 DX Months Hours (Month, Day, Year) 78 Director 229-48-6683 08/09/1932 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits Prince George MD Clinton 1 X Yes 2 ☐ No 10f. Zip Code 20735 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9106 Pineview Lane 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (SpecIfy Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ☐ Yes 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black "natural" Completed 3 Nidowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Arthur Brooks Estelle Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Brooks / Son 10503 Twin Knoll Way, Upper Marlboro, injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important; If it
any injury or o ō cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Termation 3 Removal from State 12/7/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death Dav Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has this certificate perform 1 Yes 2 N 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 | No 2 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending injury Accident Investigation M 1 Yes 2 No 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title OCD LINE CENTER WARRENT, NO

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Anna Maria 2. Date of Death 3. Time of Death A Kueberth Physician/ December 4, 2010 11:20 M Medical 4a. Facility Name (if not institution, give street and number)
Upper Chesapeake Medical Center 4b. City, Town, or Location of Death Bel Air 4c. County of Death Harford Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 🗆 M 2 💢 F Days Hours (Month, Day, Year) une 12,1922 Baltimore, MD 218-14-2792 88 Yrs. June Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏅 No Harford Abingdon 10e. Street and Number 20 Box Hill South Parkway 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Insurance Company College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Yeakle Philip Kueberth 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 204 Kings Crossing Circle Apt3B, Bel Air, MD 21014 Margaret Kueberth/Niece Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of December Dulaneyeway reterplace) Memorial Gardens 1 Burial 2 Cremation 3 Removal from State Timonium, Maryland 7, 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immeriate Cause (Final disease or condition resulting in death) Physician/ Theraci Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death g ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be 2 🗷 No Other: 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 🗍 DOA a မြ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No 24 hours after death. Funeral Director: A ☐ Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Berth Medical within 24

To the Fun.
completed fill. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00 69415 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Md 21014 peake Dr. UPPER word HLee 32. Registra's Signa

DHMH 17 Rev 7/2009

State Registrar

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Physici	an/	1. Decedent's Name (First, Middle,	Last)	0-1	· · · · · · · · · · · · · · · · · · ·	2	Date of Death		3. Time of D	
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		1014 Webb Court	give street and number) /		Baltimore	on or Death		4c. County of	NA	
Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. last	birthday)		Inder 24Hrs.	8. Date of Birth		9. Birthplace (State	or
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any		Usual Residence of Decedent 10a. State 10b. County	10c. City. To	own or Location	1				10d. Inside (City Limits
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ter dea			1 Yes 2 No	1□ Y	es 2 No spec	cifv:		Specify:	Black	
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or Attending Physician: The law requires that the death certificate be executed fler death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical Ex	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death). Last WUNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknot Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Nestig 3 Suicide 6 Could results.	Due to (or as a consequence of): b. Due to (or as a consequence of): d. AMENDED 23a, 27, 28, a 23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death 9 Unknown to contributing to death but not resurred to the label 1 Inpatient 2 EF 28a. Date of Injury (Month, Day, Year) 1 EF 28a. Date of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home to the label 28e. Place of Injury - At home	—f per 1 5 Othe R/Outpatient 3 5 Time of Inju fd.133(e, farm, street,	ME G911 1/ death 3 Ector (Specify) derlying cause given in 26.Place of Dea 3 DOA Other 4 iny 28c. Injury at W 0hrs 1 Yes 24	/11/11 opic pregnance in Part I. ath (Check on Nursing Vork? X No 1	23e. Did tob 1 Yes 24a. Was ar autops; perform 1 ✓ Yes 2 y one) Home 5 R 8d. Describe ho Subject 8f. Location (St	Month acco use contribution of the contributi	elivery Day ute to the cause of completion of cath? Other Scene d Carbon 1 or Rural Route Nun	leath? Inknown available ause of No nonox
or Attending Physician: The law requires that the death certificate be executed fler death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical Ex	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death). Last WINPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknot Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investig 3 Suicide 6 Could redeemed	Due to (or as a consequence of): b. Due to (or as a consequence of): d. AMENDED 23a, 27, 28, a 23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death 9 Unknown contributing to death but not resu Hospital: 1 Inpatient 2 Es 28a. Date of Injury (Month, Day, Year) fd.12/01/10 28e. Place of Injury - At home of the contribution of the contrib	—f per ncy 2 Fetal 5 Othe R/Outpatient 3 3b. Time of Inju fd.133(e, farm, street,	ME G911 1/ death 3 Ector (Specify) derlying cause given in 26.Place of Dea 3 DOA Other 4 ary 28c. Injury at W 0hrs 1 Yes 24 factory, office building	/11/11 opic pregnance in Part I. ath (Check on Nursing Vork? 2 K No 1 , etc. 2	y 23e. Did tob 1 Yes 24a. Was ar autops; perform 1 ✓ Yes 2 y one) Home 5 R 8d. Describe ho Subject 3f. Location (St 0 1 4 We	Month acco use contribution 2 No 3 24b. We privated? No 1 sesidence 6 with injury occurred inhaled detect and Number teal of the private	elivery Day ute to the cause of completion of cath? Other Scene carbon in the carbon	leath? Inknown available ause of No nonox
or Attending Physician: The law requires that the death certificate be executed fler death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical Ex	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknother under the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Natural 5 Pendin 1 Pending 2 Accident Investig 3 Suicide 6 Could reference with 1 Pending 29a. Certifier 1 Certifyling Physical Country Indicated Physical Country Indicated Physical Pending 29a. Certifier 1 Certifyling Physical Pending 2 Physical Physical Pending Physical Physical Pending Physical Physical Pending Physical Physical Pending Physical	Due to (or as a consequence of): b. Due to (or as a consequence of): d. AMENDED 23a, 27, 28, a 23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death bwn 9 Unknown The contributing to death but not resurce of the contributing to death but not resurce of the contribution of the cont	-f per ncy 2 Fetal 5 Othe Strong in the unce Strong of Inju fd.1330 e, farm, street, nce death occurrer	ME G911 1/ death 3 Ector (Specify) derlying cause given in 26.Place of Dea 3 DOA Other 4 iny 28c. Injury at W Ohrs. factory, office building, d at the time, date and	/11/11 opic pregnance in Part I. ath (Check on Nursing) fork? X No i, etc. 2	23e. Did tob 1 Yes 24a. Was ar autops; perform 1 ✓ Yes 2 y one) Home 5 R 8d. Describe ho 5 D C Town, State 0 1 4 We lie to the cause	Month acco use contribution of the contributi	elivery Day ute to the cause of or Probably 4 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	leath? Inknown available ause of No nonox
he death certificate be executed y the attending physician and hed for use as the burnal - transit	Be Completed by Physician/Medical Ex	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknother under the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Natural 5 Pendin 1 Pending 2 Accident Investig 3 Suicide 6 Could reference with 1 Pending 29a. Certifier 1 Certifyling Physical Country Indicated Physical Country Indicated Physical Pending 29a. Certifier 1 Certifyling Physical Pending 2 Physical Physical Pending Physical Physical Pending Physical Physical Pending Physical Physical Pending Physical	Due to (or as a consequence of): b. Due to (or as a consequence of): d. AMENDED 23a, 27, 28, a 23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death 9 Unknown contributing to death but not resu Hospital: 1 Inpatient 2 Es 28a. Date of Injury (Month, Day, Year) fd.12/01/10 28e. Place of Injury - At home of the contribution of the contrib	-f per ncy 2 Fetal 5 Othe Strong in the unce Strong of Inju fd.1330 e, farm, street, nce death occurrer	ME G911 1/ death 3 Ector (Specify) derlying cause given in 26.Place of Dea 3 DOA Other 4 iny 28c. Injury at W Ohrs. factory, office building, d at the time, date and	opic pregnance Part I. Ath (Check on Nursing lork? No 1 I place, and di occurred at t	23e. Did tob 1 Yes 24a. Was ar autopsy perform 1 Yes 2 y one) Home 5 R 3d. Describe ho 5 Ub ject 3f. Location (St 0 1 Yewn, Ste 1 We to the cause are time, date ar	Month acco use contribut 2 No 3 24b. We printed the	elivery Day ute to the cause of or Probably 4 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	leath? Inknown available ause of No monox mber, City

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Russell Alexander MD.

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 4. 2010 JEAN LANDON 5:02 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Indiana Nov. 17, Year 1948 Hours Min. **Director** 458-78-4584 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Savage 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20763 U.S.A. 8472 Savage-Guilford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXIII Black, White, etc. Completed by 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 Data Entry Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thomas Osborne Katherine Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter E. Landon spouse P.O. Box 41 Savage, Maryland 20763 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🛣 remation 3 🗀 Removal from State cemetery, crematory or other place) Arundel Crematory | 12/9/2010 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PIABOTES 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 RR 140515 2 🗆 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dether (Specify) +OSPICE Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled i Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JV/ CI-IAE/ 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 12 3:19AM Lutman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maryland Med Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye OCt 17, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2XXF Days 579-64-3502 64 Washington, DC Director Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Laurel 1 Yes 2 No Howard Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if item 27 is marked other than "... any injury or other traums**. U.S.A. 20723 10512 Patuxent Ridge Way 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Air Force Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal / Office Manager vears Law Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Ball Herbert Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, Maryland 20723 10512 Patuxent Ridge Way Walter J. Lutman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XXremation 3 Removal from State Arundel Crematory 12/5/2010 Odenton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility ral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disea se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final Physician/ ulmonar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 \(\sum \) No X Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 XNO Other: မ 1 Tyes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar 225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

2100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Physician/ NYC 1:38P M 22 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERU Washington Adventist HOSPITA ar 10 KOMa 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Seuth Korea Days (Morith, Day 1 M 2 X F 8 Months 215-04-7862 5 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 💢 No MONTGOMER ak MA OMA 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country Funeral 2083 10C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) omest Tousew Be 18. Mother's Name (Firşt, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ now UNI nown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ö 0 20a. Method of Disposition 20b. Place of Disposition, (Name of 20c. Location City or Town, State cemetery, cremator) or other place 1 Burial 2 Cremation 3 Removal from State (rate eaven 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee an 20191 0220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OC Sequentially list conditions, Examine Due to (or as a con equence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 1 🗹 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) Signature and title A 29d. Date signed (Month, Day, Year) 29b. 20 2010 US es of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre CAHC NOVE 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:50 P M November Richard Anthony Lawrence Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yo October 30 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours New York 1 X M 2 □ F 1928 103-20-3574 82 Director Usual Residence of Decedent shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No 28a-f Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe 23a 8512 Howell Road 20817 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. rmed Forces?

Yes 2 No Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Korea Specify: White "natural", 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event than "ne once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Newspaper Columnist/Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) မ James Russell Lawrence Alice Streuli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8512 Howell Road Bethesda, Maryland 20817 Vera Lawrence/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition December 4 cemetery, crematory or other place) 1 🗌 Burial 2 🗵 Cremation 3 🗌 Removal from State ontgomery rematorium, 2010 Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Bethesda-ChevyChase Inc.
7557 Wisconsin Avenue Bethesda Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fureral Service Liven MO1607 57 Wisconsin Avenue Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Parkinson's Sequentially list conditions Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Cerebrovascular Accident Due to (or as a consequence of): resulting in death) Last Physician/Medical Sacral Decubitus IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ் Live Birth 2 ⊔ reเล பகவ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ Failure to thrive 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify, Hospital: 2 🔀 No 1 TYes 1 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 1 X Natural 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | 3 | only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of

Ajay

Reddy,

VO

32. Registran Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D53691

3200 Tower Oaks Blvd. Rockville, Maryland 20852

November 30, 2010

1.			Р	lease					nk. Ensure			_	•
Q			For		State of M	arylan	d / Depa	artment of	f Health and	Mental Hy	giene	0010	00001
1		1	State Registrar				Cer	tificate o	f Death		Reg. No	ZUIU	38204
		_	1. Decedent's Name (First, M	liddle, Last	·)					2. Date of De			3. Time of Death
Ö	Physicia Medic	_			Joseph	Ρ.	McCart	hy		Decemb	er 2	2. 2010	7:00 P ^M
0	Examin		la. Facility Name (if not institu	ution, give s				4b. City, Town	, or Location of Deat	h	4c	. County of Deat	th
1			4233 Newport	Aver	nue			Balt	imore			N/A	1
/	Funeral		5. Social Security Number	6. Se:		e (In yrs. la	ıst birthday)	If Under 1 Ye Months Day	ar If Under 24 Hrs		th v Vear	9. Bir	thplace (State or Foreign
0	Director		213-28-7480	1 1 1	XM2UF		79 Yrs.	WOTHERS	yo Hours Will.	May 6,	<u>"193</u>	1 <u>Ma</u>	ryland
,	, MC		Usual Residence of Deceden			100 City	, Town or Lo	nation					10d, Inside City Limits
PK	ye 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the fleath and Mental Hygiene. The fleath 23 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	당		,		Tuc. City	, IOWII OF LO						1 1 Yes 2 □ No
1	Mar 28a sotifi	į	MD	N/A				Balti					21
4	h the	a	10e. Street and Number					10f. Zip Cod			10g. Cit	tizen of What Co	ountry?
	h wit	Funeral Director	4233 Newpor	ct Ave					21211	-16 - 1/2 1/2		USA	
	deat riten ner	F	11. Marital Status		12. Was Decedent Armed Forces?		3. 13. \	Nas Decedent of f Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	pecity Yes or No- to Rican, etc.)	- 1	Race - Ame Black, Whit	
98	after	d by	1 ☐ Never Married 2 ☐ 3 👿 Widowed 4 ☐ Divo		1 Yes 2 L If Yes, Give	Korea	a .	I□Yes 2😿	No Specify:			Specify: LT	hite
y	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", ar items 25a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed	21	cedent's Ed	Year or Dates.		16a Decer	dent's Usual Oc	cupation		16b K	(ind of Business	
V 75	72 h n "na Aedia	ם	(Specify only	highest grad	de completed)		(Give	kind of work doi O NOT use retir	ne during most of wo	rking	100.10	ilia di basiless	moustry
72	ithin ene. r tha the N	Ö	Elementary/Seconday (0-	12)	College (1-4 or	5+)		Pool I	•		U.S	G. Gover	nment
d 2	Hygi othe	Be	17. Father's Name (First, Mid	dle, Last)						me (First, Middle,			
≥ E	be fill ental rked ic ev	욘	Peter				McCart	hv	Mary	Не	len.	Gi	111
Mary	should be fill and Mental is marked raumatic ev	ŀ	19a. Informant's Name/Relat	tionship (Ty)	pe, Print)				eet and Number or Ru			Town, State, Zi	p Code)
_Σ	12 shulth ar 27 is r trau		Leslie D. Tay	back.	. daughte	r			Avenue	Baltim			.211
	and Hea Item other		20a. Method of Disposition			20b. P	lace of Dispo	sition (Name of		Date		ocation - City or	
CAR. Baltimore,	Page nent o		1 ☐ Burial 2 💢 Crema 4 ☐ Donation 5 ☐ Ot	ation 3 🗍	Removal from State	7		natory or other p omatory	, Inc. 12,	/03/10	В	altimor	e MD
	permit. Page Department (Important: It any injury or once.		21. Signature of Funeral Sen						dress of Facility				
$\mathcal{O}_{\mathbf{g}}$	permit. Departn Importa any inju		Ser E	M	George	Macina —			ederick Ro			nore, MI	
0			23a. Part 1. Enter the diseas	se, or comp	olications that cause	d the deat						iore, in	Approximate
5			shock, or heart failure. Immediate Cause (Final	List only on	ne cause on each lin	e.	1:0		100+1				Interval Between Onset and Death
1	hysician/ Medical	9	disease or condition resulting in death)		a. Due to (or as	a conseni	ience of).	myo	pain	4			WEEKS
	Examiner				240 10 (01 40					(
	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ner	Sequentially list conditions, if any, leading to immediate	,	b. Due to (or as	a consequ	ience of):		· · · · · · · · · · · · · · · · · · ·				
NA		Examiner	cause. Enter Underlying Cause (Disease or iinjury	5									
×			resulting in death) Last	at initiated events									
2		ical											
6876		Physician/Medi						-					
000		an/a	IF FEMALE: 23b. Was decedent pregnan	t :	23c. If yes, outcome 1 Live Birth			Ectopic pregr	nancy			23d. Date of de	
200		sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregnant	at time of o		Other (specify				Month	Day Year
70		چ	9 Unknown										
12.	that gned se de	ا ۾	Part II. Other significant co		ontributing to death	but not res	h-		e given in Part I.			1	the cause of death?
ds,	quire; en siç ould b	Completed	Coronal	4 /	the tell	10	1 26	ase		1 🗆	Yes 2	¹□No 3□F	Probably 4 Unknown
Ö	To the Hospital or Attending Physician: The law requires that the within by 45 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	ble		·		`				24a. Was auto		prior to	utopsy findings available completion of cause of
æ	The law cate has page 2:	le l								perfo 1 \sum Yes	ormed?	death?	s 2 No
<u>=</u>	sician: The law certificate has rector, page 2 s	Be	25. Was case referred to me examiner?	-					6. Place of Death (Che				
Zi.	lysici is ce direc	2	1 Yes 2 No	1	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie	nt 3 🗆 DOA	Other: 4 Nursing	Home 5 Resi	dence 6	3 ☐ Other (Spe	cify)
Division of Vital Records,	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ F	ending	28a. Date of inj (Month, D	ury ay, Year)	28b. Time of injury		njury at vork?	28d. Describe I	how injur	y occurred	
o	endir sath. or: Af he fu	lica	2 Accident Ir	vestigation					Yes 2 No				
/İSİ	r Att	Certificate:		Could not be etermined	28e. Place of In	jury - At ho tc. (Specify	ome, farm, str	eet, factory, offi	ce	28f. Location (ural Route Number,
امّ	ital o Irs af ral Di												
	To the Hospital or Attending Physician: "In the Funeral Birector After this certific completed filled in by the funeral director,	Medical	(Check O Med	ical Evami	ner: On the hasis of	examinatio	n and/or inves	stigation, in my o	time, date and place, pinion, death occurred	at the time, date :	and place	 and due to the 	cause(s) and manner stated.
	the thin 2 the I	ž	only one) 3 Cert 29b. Signature and title of ce	ifying Nurs	e Practioner: To th	e best of m	y knowledge,	death occurred a	at the time, date and pense number	lace, and due to th	ne cause(s) and manner as ate signed (Mont	s stated.
	5 ≥ 6 0				nnderi	IM		2	100 COV	179	17	1 - 1	OID
							00.1.7		, , , ,	() '		1710	
	1,71		30. Name and address of pe	-	completed cause of	_	1 23a) (Type, I	Print) Fa	00002	ROND-	h'm	Ur9.	11515 CM
	Y		31. Date filed (Month, Day, M	earl as a	10	rar's Signa	ture	<u> </u>	coon of 1	2000	16.1	, () /	D
	Sta Registr		UEU V"?	2010	Anen	D.	Back	and a					

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		-	For State Registrar	State of Mar		epartmer Certificat			Mental Hy	giene Reg. No.	10	38205	
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)	1) A		10			2. Date of De Month	eath Day	Year	3. Time of Death 9:55 A M	
	Medic Examin		4a. Facility Name (if not institution, give str		rager	4b. City.	Town, or Le	ocation of Dea	December 1		⊋Ö\Û nty of Death		
	Ladiiiii	Ŭ.	Novethicest	- Haspi	tal			Julista			celtin		
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birth		1 Year	If Under 24 Hr Hours Mir	8. Date of Bi	th Yea <i>r)</i>	9. Birth Cou	nplace (State or Foreign	
	Director >		215-60-0411 Usual Residence of Decedent		50 .	10.			1 3-3-19	04		MD	
	yland f shoved at	tor	10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits	
	r 28a- notifie	Sire	MD n/a 10e. Street and Number		Balt	imore	Code					1 Yes 2 □ No	
	vith th	rall	6608 Marott Drive			101. 21	21207	7		10g. Citizen		untry?	
	tems			. Was Decedent Ever	in U.S.	13. Was Deced			Specify Yes or No to Rican, etc.)	14. F	Race - Amer		
36	after d I", or i camin	by	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 \(\superstack \text{Yes}\)			to Ficari, etc.)	Spec	Black, White	, etc. rican-American	
8	atura cal Ex	Completed	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates. ation	Dates. 16a. Decedent's Usual Occupation				_		f Business I		
215	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minortant: If item 27 is marked other than "natural", or items 23a or 28a-f show minor injury or other traumatic event, the Medical Examiner must be notified at anne.	dmc	(Specify only highest grade Elementary/Seconday (0-12)		(Give kind of wo life. DO NOT use	rk done dur		orking	IOD. KING O	Dusiness ii	ndustry	
2		a l		2	Security						n Enter	prises	
and		To B	17. Father's Name (First, Middle, Last) Robert Lee Morgan Sr.					18. Mother's Na Virginia	ame (First, Middle Hill	, Maiden Surna	ıme)		
aryl	nould I		19a. Informant's Name/Relationship (Type	Print)	19b.	Mailing Address			ural Route Numb	er, City or Towr	n, State, Zip	Code)	
Σ̈́	nd 2 sh salth a nn 27 is ertra		Joyslon M. Smith-Morgan	√ Wife	66	08 Marot	t Drive	e, Baltir	nome, MD 2	1207		,	
Baltimore, Maryland 21215-0036	ge 1 ar nt of He : If iter or oth		20a. Method of Disposition 1		cemetery	Disposition (Nar crematory or c	ther place)	40.4	Date	20c. Locatio	•	Town, State	
<u>#</u>	artmer artmer ortant injury		21. Si na ve of Funeral Service Licensee		King Me	morial Pa			0-2010	Woodlaw		Raito. Co.	
Ba	permit Depart Impor any in	6 9	Mandai	M. Cell	Ree				rdallstown			1.024	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do no	ot enter the mod	e of dying,	such as cardia	ic or respiratory a	rrest,		Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	Love	Avve	S				\rightarrow	Onset and Death	
	Examiner			Due to (or as a co	onsequence of	D A							
	, ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a co	onsequence of	sequence of:							
D	ecuted and transi	xam	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of						\rightarrow		
_	icate be executed j physician and is the burial-transit	dical Examiner	resulting in death) Last	. 1	en te	•							
3760	ficate g phys	/edi	d.	1900	TC-TC-	72/01/	•			74			
Box 68760	r use a	an/N	Zob. Was decedent pregnant	c. If yes, outcome of p	3 🗆 Ectopic	Ectopic pregnancy				23d. Date of delivery Month Day Year			
Bo	requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ve Briti 2 Petal death 5 Other (specify) 9 Unknown							1650	Month	Day Year	
Ö.	hat the ed by detacl	by Ph	Part II. Other significant conditions conti	ibuting to death but r	not resulting in	the underlying	cause giver	n in Part I.	23e. Did	tobacco use co	use contribute to the cause of death?		
ls, l	uires t in sign uld be	ed b	-						. 1 🗆	Yes 2 N	o 3 € Pr	obably 4 🗆 Unknown	
Sor	aw red as bee 2 sho	Completed							24a. Was ar				
Re	The la	Con							per 1 \(\sum \) Yes	ormed? 2 No	death?	2 No	
ita	sician; certifi rector	Be C	25. Was case referred to medical examiner? 1 Yes No	spital:			Other	e of Death (Ch					
of V	g Phy er this eral d	te: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of injury (Month, Day, Yo	28b. Ti		8c. Injury a		Home 5 Res 28d. Describe	idence 6 □ 0 how injury occ		fy)	
o	eath. or; Aft	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(IVIONIN, Day, 16	ear) In	jury M	work?	es 2 🗆 No					
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director, Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S		m, street, factor	y, office			(Street and Nur wn, State)	nber or Run	al Route Number,	
Ω	ospital hours ineral d filled	Medical	29a. Certifier 1 Certifying Physici	an: To the best of my	knowledge, d	eath occured at	the time, d	date and place	and due to the c	ause(s) and ma	anner as sta	ted.	
	the Ho hin 24 the Fu	Mec	only one) 3 Certifying Nurse I			edge, death occu	rred at the t	time, date and p		he cause(s) and	manner as		
	5 <u>4 ¥</u> €		29b. Signature and title of certifier	Morose T	00	290	License n			29d. Date sig		, Day, Year) 3 3010	
	1		30. Name and address of person who com	pleted cause of deat	h (Item 23a) (T	ype, Print)	,10	- (70-0			
	6		5461 Old Coved Tho	11	11 h	WM	D:	21133					
П	Stat Registra		31. Date filed (Month, Day, Year) RFC 0 7 2010	32. Registrar's	Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 38206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gladys Amos Myers Month December 05,2010 12:35 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove Hospice Westminster Carroll Co. 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 15, 1927 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏿 F Months Days Hours 220-18-5537 Elkton, Virginia Director 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Carroll Co. Hampstead 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4214 Black Rock Road 21074 United States items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? ō 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates "natural" Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working land 2121 other than College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ashby Crawford should be 1 Nancy Irene Shifflett Baltimore, Maryì 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r Mrs. Kathryn A. Hollands Page 1 and 2 Health 4214 Black Rock Road Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of Thursday ŏ Important: If it any injury or o (Baltinore Co. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dularey Valley Men Gardens Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dec. 10, 2010 See Jeffrey L.Gair, Sr. Function (enter, P.A. 2325 York Road Timonium, Maryland 21093-2215 av. Lic. #100677 23a. First 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) **Medical** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 W 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 X No After this 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide after death 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Division of Vital Records, P.O. Box 68760 24 hours a within 2

> 30. Name address of person who completed cause of death (Item 23a) (Type, Print) 68 ^{Year} 2010 State 32. Registrar's Signature Registrar

Certifying Nurse Practioner To the best of my knowledge, or

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

dist the time, date and place, and day to the cause(s) and manner as stated

29a. Certifier (Check

29b. Signature

and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38207 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howard Malcolm Miller December 06,2010 6:35 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Days Months Hours June 03, 1942 219-38-0349 68 Baltimore, MD. Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2 🔀 No Maryland Baltimore Co. Towson 10e. Street and Numbe 10f. Zip Code must be n 10g. Citizen of What Country? 111 West Road 21204 United States ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. er than "natural", the Medical Exa 3 Widowed 4 Divorced Specify White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Title Abstractor 12 08 Real Estate other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic ever t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked oliury or other traumatic even မ Harry Manuel Miller Mildred Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Melissa M.Beatty (Daughter) 804 Stags Head Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth Location - City or Town, State (Baltimore Co.) 1 Burial 2 Cremation 3 Removal from State Thursday Mishkon Israel Cem. 4 Donation 5 Other (Specify) Dec. 09, 2010 Rosedale, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Reaceful Alternatives Funeral & Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Memshanc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner osquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal gear 4 ☐ Pregnant at time of death 9 ☐ Unknown Year Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tomash 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops After this certificate 2 No 1 Yes il or Attending Physician; I after death. Director: After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 7:00am M Dean Miller Leroy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 19 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 🔀 M 2 🗆 F Hours Year. Country) Maryland Vrs **Director** 215-20-8338 84 1926 Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** Owings Mills 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with U.S.A. 4829 Deer Park Road 21117 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates. WW II White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Carpenter other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H 7 is marked of ည should be Viola Frick Wilbur Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Linda Miller Duncan Page 1 and 2 31 Brandywine Drive Shrewsbury, PA Daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/7/10 Deer Park Cemetery Westminster, MD 22. Name and Address of Facility 11824 Reistertown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Certificate; To Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Doe to for as a consequence on Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicarpited filed in by the funeral director, page 2 should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Lunkhown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 1 Other: 1 Lupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -0054218 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Raman B. Kaneng 343 Mallalu, dure, westmunter the

Registrar

State

Date filed (Month, Day, Year)

Box 68760

P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joseph Francis Mealy, Jr. 2010 December 4 6:38A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7117 Wolftree Lane Rockville Montgomery
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year

 Feb. 28, 1
 9. Birthplace (State or Foreign Country) Washington, DO **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 **X** M 2 □ F Director 577-46-9483 76 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Tes 2xxNo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 7117 Wolftree Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager/Senior Executive Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Gertrude Garner Joseph Francis Mealy, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Pope/Daughter 12000 Market Street, #318, Reston, Virginia 20190 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 X Burial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) 11, 2010 Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home 21. Signature of Funeral Service Ligeosee any Rockville, Rockville, Inc. 300 West Montgomery Avenue Maryland 20850-2805 M00803 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Du ti (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? Yes 2 No After this certificate 2 No 1 Yes Be 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 2 X10 Other: 1 Yes 잍 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

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State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2250 Walter Edward Markward 03 20 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico the SAlisburg HOSDICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 ★M 2 ☐ F 578-50-1245 Months Hours Country) 69 Yrs Director 04/21/194 Usual Residence of Decedent 10b. County 10a. State death with the Maryland 10c. City, Town or Location notified at Director 10d. Inside City Limits Berlin 28a-f MD Worcester 1 XYes 2 No 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code traumatic event, the Medical Examiner must be Funeral Camelot Circle 21811 108 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinonce. δ Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give White Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Eleanor Creighton Walter ပ Markward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 2605 Florence Road, Woodbine, MD 21797 Son Scott E. Markward 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State Final Journey Crem. 12/8/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD wousha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 🗌 No 3 Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed' death? 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 50. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 7/2009

State Registrar GREGORIO M.

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32. Regist

M.D.

5302 CHINABERRY DR., SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Year Eva Jessica O'Neill December Ам 8:00 . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 5, 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🗆 M 2 🗓 F Months Slovakia 216-68-1762 Yrs. Director 1953 Usual Residence of Deceden or 28a-f shov or items 23a or 28a-f shorminer must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 S. Fallsmead Way. 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", White 3 ☑ Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Important: If item 27 is regard any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ambroz Karol Skrovanek Camilla Irena Gruner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia O'Neill / Daughter 1915 S. Fallsmead Way, Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State December 10 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, MD 20850 Haran M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Small Cell Carcinoma of the Liver disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Line Uniderlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by urrafter death. eral Director. After this certificate has been signe filled in by the funeral director, page 2 should be r Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practiciner To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifield 29d. Date signed (Month. Day, Year) D67986 December 4, 2010

DHMH 17 Rev 7/2009

State Registrar

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Ytineng Li, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oden 16:49 Physician/ Month 11Zabeth Marie 2010 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🛣 F Days Hours 10/07/1942 Marýland Director 218-38-9994 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Director 1 X Yes 2 No Anne Arundel Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20724 5 Rose Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11 Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Paralegal 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mae Theresa Brook Oden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2485 Widgeon Drive, Clarksville, TN 37042 Matthew King / Son 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 12/06/2010 Hanover, Maryland 4 X Donation 5 Other (Specify) Anatomy Gifts Registry Signature of Funeral Service Licen se 22, Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final odgkin's mphona Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part !I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available 24a. Was an cate has t prior to completion of cause of death? performed? Yes 2 No Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 5+

21201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amantha Smith 27 S Greene

32. Registrar's Signature

10-08747 Franklin Owens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

anklin Owens		te of Death	Reg. No.	1 38213
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Examine		I no an I no at Double	Month Day Year November 15, 2010	0402 hrs
	4a, Facility Name (if not institution, give street and number) 8370 Beachwood Park Road	4b. City, Town, or Location of Death Pasadena	Anne Arundel	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		B, Date of Birth (MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
Director	217-52-5893 1x ² M 2□F 61	Yrs. Months Days Hours Min.	1	ARYLAND
	Usual Residence of Decedent	Location		10d. Inside City Limits
w any	10a. State 10b. County 10c. City, Town of			1 X Yes 2 No
Maryland 28a-f show any <u>d at once.</u> ector	MD. ANNE ARUNDEL PASADI	INA 10f. Zip Code	10g. Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once. al Director	8370 BEACHWOOD PARK RD.	21122	USA	
with the ris 23a se noti	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,
or items 23	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No			The state of the s
s after ral", c	3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. D	Yes 2 X No specify: ecedent's Usual Dccupation (Give kind of w	Specify: BL,	
hour "natu	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retir	ed)	
-0036 within 72 hour giene. her than "natu Exau Exau Completed	-124-	TEACHER		RE, CITY
5-0(led wi Hygier I other the M			(First, Middle, Maiden Surname) Y PETERS	
21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	FRANKLIN A. OWENS, JR. 19a. Informant's Name/Relationship (Type, Print) 19b	Mailing Address (Street and Number or F		e, Zip Code)
AD 2 2 shoul 1 and N 27 is n matic		50 SOUTH ST. ANNAPOL	IS, MARYLAND 2140	1
e, N I and I and Health Health	ZCG. MOUTOWOT DISPOSITION	Disposition (Name of cemetery, ry or other place)	Date 20c. Location - City of	r Town, State
MOI Pages ent of int: If	1 Burial 2 Cremation 3 Removal from State cremato 4 Donation 5 Other Specify: METRO		4-2010 BALTIMORE	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	21. Signature of Lineral Servicesticesee J. N.A. HAN D. HIB.	NAME Name and Address of Facility PHI 1721-27 N. MONROE	LLIPS FUNERAL HOM	E, P.A.
	23a Tart I. Enter the disease, or complications that caused the death. Do no			Approximate Interval
Physician Wedical	failure. List only one cause on each line.			Between Onset and Death
Examiner	or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ai a	cause. Enter Underlying Cause (Disease or injury that initiated			
ted Insit	events resulting in death) Last Due to (or as a consequence of):			
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760, cate be physici he buri			23d. Date of delive	Day Year
ox 6876(eath certificate tatending phy for use as the by	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	=	ancy Month	Day Tour
). Box 6876 the death certificate by the attending phy ched for use as the	1 Yes 2 No 9 Unknown 9 Unknown			U of doalh?
P.O. es that the signed by the detache		g in the underlying cause given in Part I.	23e. Did tobacco use contribute t 1 Yes 2 ✓ No 3 Pr	
ords, P			24a. Was an 24b. Were a	autopsy findings available
Records, The law requires ficate has been sign page 2 should be			performed? death?	
tal Rec	25. Was case referred to medical	26. Place of Death (Check	only one)	Yes 2 No
Vital ysician ysician directo	examiner? Hospital: 4 Innoticet 2 FD/O	utpatient 3 DOA Other Nursin	ng Home 5 Residence 6 🗸 Oth	er: Scene
of Vi		Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject shot self	·
ion ttendi death.	1 Natural 5 Pending Nov 15, 2010 0330 2 Accident Investigation	1 100 2 100	28f. Location (Street and Number or F	Rural Route Number City
Division of Vital Records, spital or Attending Physician: The law requiremental for the law found mental Director. After this certificate has been similared in by the funeral director, page 2 should be extended.	3 ✓ Suicide 6 Could not be determined (Specify) At residence	arm, street, factory, office building, etc.	or Town, State) 8370 Beachwood Park Road, Par	
y fill hou		ath occurred at the time, date and place, and	due to the cause(s) and manner as st	ated.
To the F within 2. To the F complete	(Check only 1 Certifying Physician: To the best of my knowledge, define) 2 Wedical Examiner: On the basis of examination and/or i and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
£ \$ £ 8		29c. License number	29d. Date signed (M. November 15,	
	high, mos	O.C.M.E.	TADVELLIDE: 10,	
7	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Pen	n Street, Baltimpre, MD 21201		
Sta	22 Pegistrat's Signature	harled		
Pogietr		ALL ROOF		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day WID Year p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Parkville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 XX Yrs 03/11/1915 Marviand **Director** 214-03-1760 Usual Residence of Decedent ms 23a or 28a-f shormust be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XX No Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8822 Walther Blvd 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceud... Armed Forces? Ves 200 No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Black, White, etc þ 1XX Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. Specify Completed 3 Widowed 4 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Manufacturing t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant; If item 27 is marked other i njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Frederick Edward Plantholt Catherine Margaret Brunner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Plantholt Nephew 9003 Golden Pass Laural Maryland 20708 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department or Important; If any injury or 1 💢 Burial 2 🗌 Cremation 3 🗀 Removal from State Most Holy Redeemer Cem 12/07/2010 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's 2 🗌 No Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (C > k only one) examine? Hospital 2 🗆 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title q ense number 30. Name and address of p on who completed gause of death (Item 23a) (Type, Print) numlk WW3-608, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 5:00 A M December Rosemary Catherine Parisi 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Cockeysville Broadmead 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 1928 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours 82 1 □ M 200 F May 149-20-9699 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 X No Cockeysville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 United States 45 Atherton Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Ye*s* 2**X** No If Yes, Give Year or Dates: Specify: white 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Villanova Romeo Evangelista 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lutherville, MD 21093 45 Atherton Rd. Daniel Parisi/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardDec. 8,2010 Timonium, Maryland Donation 5 Other (Specify) Signature of Funeral Sorvice Licensee 6500 York Rd. 23a. Part 1. Enter the dise vie, or complibitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2 ☑No 1 □Yes 26. Place of Death (Check only one) Other: 4 Prursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident

Examiner 5:00 Am P.O. Box 68760, 12/5/10 Division of Vital Records, DARISI Zosemnay

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans attending pl completely filled in by the funeral director, page 2 should be det

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination be resident and note.

Physician

/Medical

Baltimore, Maryland 21215-0036

Physician/Medical 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical examiner? Certification: To 27. Mann of Death 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

32. Registrar's Signatu 2010

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Cockeys ville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edith Physician/ PHSLO No remper 9:15 P M Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Seasons Hospice 5. Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Hours (Month, Day, Year) 216-12-9601 Director 87 13-1923 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Funeral Director 10d. Inside City Limits Baltimore n/a 1X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4161 Crest Heights Road 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: African-American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th Caretaker Self-Employed other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Gardner Sr. Mary Frances Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Schnaper Drive, Randallstown, MD 21133 Linda Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place)
Arbutus Manorial Park 1X Burial 2 Cremation 3 Removal from State 12-6-2010 Arbutus, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Party | Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest and see Cause (Final End - Strate Demontial) Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be dei 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Tother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the comple 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) · nskyrpameM.D 00057465 12/11/0 N. S. RYAPAKA, M.D. 2835 Smin AV-S-203 - Baltimore, MD. 21709. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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2010

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Christopher Pete		1- For State	tate of Maryla		rtment of tificate of		Menta	п пуд		g. No. 20	10	38217
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd		istophe	er Pet	erson			Date of Death Month November	า	. 1	Time of Death 2005 hrs
		4a. Facility Name (if not institution 319 Magothy Road	on, give street and no			. City, Town, or L Pasadena				4c. County of Anne Art	ındel	
Funeral Director		5. Social Security Number 151-82-8840	6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		3. Date of Birtl	1985 1987	9. Birthpl Foreign Countr	NT T
th the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number	Arundel		Town or Locatio	Severn			10	g. Citizen of Wh	1 at Country	od. Inside City Limits Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	319 Magothy 11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Di	12. Was De	2 X No	If Yes	Decedent of Hispons, specify Cuban, leading of the company of the	Mexican, P	? (Specif		14. Race - White		ı Indian, Black,
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and 2 should tealth and Mi tem 27 is ma	£	19a. Informant's Name/Relation Randolph Pet	ship (Type, Print) Cerson /	Father	319		Roa	d,		na Parl	k, M	D 21146
Baltimore, Nermit. Pages I and Department of Health Important: If item injury or other trau		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	pecify:	rom State Fi	nal Jour	on (Name of ceme r place) ney Cren me and Address o	n. ´		/2010	Woodbi		
Ba permi Depa Impo injur		21. Signature of Funeral Service	Charles	shall		Maryla PO Box	and 0	rem	ation Balti	Servi more,	ces MD 2	1203
Physician Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting In death)	on each line.		(diphen	hydramin						Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be executing after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the builal	siciar	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 23c. If yes,	outcome of pregi pirth nant at time of de	nancy 2 Feta	g910_12/			,	23d. Date of o	delivery Day	Year
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To the Ho within 24 ! To the Fu	Medical	one) 2 Medical Exa	hysician: To the be aminer:On the basis and manner:	of examination a		n, in my opinion, o	death occur				e to the ca	
	Σ	29b. Signature and title of certification of the other X	(King	Tana	u.).	29c. License O.C.M		DCME		November 2		
5		30. Name and address of person Theodore M. King. Jr	0			11 Penn Stre	et, Baltii	more. N	MD 21201			

State 31. Date filed (Month, Day, Year)
Registrar IFC 0 7 2010

32. Registrar's Signature

	-	For State		State of	Marylan	-	irtment of F <i>tificate of</i>	Health and M <i>Death</i>	1ental Hy			00210
		Registrar 1. Decedent's Name (Fit	st, Middle, Las	st)				Douth	2. Date of De	Reg. No).	3. Time of Death
Physician	-	George	L. Rei	ichle					Month	Da	2010	5:07PM
/Medical		4a. Facility Name (If not			er)		4b. City, Town, o	r Location of Death	500	4c.	. County of Dear	
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Funeral		Social Security Number	er 6. S	ex 7.	Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth	9. Bir	thplace (State or Foreign ountry) W York
Director		087-03-375	0 -	(□ M 2□ F	98	Yrs.			Feb. 1	2, 1	912 Ne	w York
and w		Usual Residence of Dec 10a. State 10b	. County	.	10c City	y, Town or Lo	ration					10d. Inside City Limits
laryla Shor	- 1		Baltimo	ro	100.00	y, 104411 01 LO		nsville				1 □Yes 2X No
the N	5 2	10e. Street and Number	- LINC	<u> </u>			10f. Zip Code	13 1 1 1 1 1	T	10 08	tizen of What Co	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercise must be notified at once.	5	709 Maiden	Choice	In. RG	V 221		Toi. Zip code	21228		-	ited St	-
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ffer of free free free free free free fr		1 Never Married	2 Married	Armed Force	es?				Rican, etc.)		Black, White	e, etc.
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21215-003(ed within 72 hours a ygiene. her than "natural"; of t, the Medical Even		15. (Specify of	Decedent's Ed	lucation de completed)		16a. Deced	ient's Usual Occup	oation	ina		(ind of Business	
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Mal 12 st h and 7 is n traun		19a. Informant's Name/					•	and Number or Rura				Zip Code)
e, land Healt Healt ther 2	-	George C. 20a. Method of Dispositi		e / Son	20h B			Dr., Cent	erport		ocation - City or	Town State
ages nt of nr of or o		1 ☐ Burial 2 🗓 Cre	emation 3 🗆	Removal from Sta	ite Mod	emetery, cren	sition (Name of natory or other place	ce) 12/06			•	
Baltimore, Maryland 21215-0036 Demit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any holury or other traumatic event, the Modical Exertions. To Re Completed by E	-	4 □ Donation 5 □						Inc 12/06				Maryland
Ba Perm Depa Impo any i	Į	21. Signature of Funeral	Service Licen	see AllySOI	i k lay		. Name and Addre	Ma	cNabb I	Tuner	cal Home	P.A.
	+	23a. Part 1. Enter the dis	sease or com	olications that cau	sed the death			ick Rd.,			e, MD 21	L228 Approximate
		shock, or heart fail	ure. List only	one cause on eac	h line.	i. Do not ent	_		or respiratory t	arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	-	a. As	pirat	404	Pheun	nonia				4 days
Examiner		-	- 1	Due to (or	as a consequ	uence of):						
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executed an and ial-transit	1	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<	·		,						
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Sicilia Burn	3			. d								
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Box 6		IF FEMALE: 23b. Was decedent preg		23c. If yes, outco	me of pregna h 2□ Fetal] Ectopic pregnanc				23d. Date of de	livery
dead dead of for sicilar	2	in the past 12 mont 1 □ Yes 2 □ No	hs?		nt at time of d		Other (specify)	, y			Month	Day Year
λ e i c h h h h h h h h h h		9 🗌 Unknown							177			
ds, lires the signed to be de	2	Part II. Other significant	conditions o	ontributing to deat	h but not resu	Ilting in the ur	derlying cause giv	en in Part I.				the cause of death?
$\mathcal{E} \cap \mathcal{L} / \mathcal{E}$ Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be completed by									1 🗆	Yes 2	□ No 3 □ P.	robably 4 🗗 Unknown
al Record The law require cate has been so page 2 should	2								24a. Was		24b. Were at	utopsy findings available completion of cause of
e i こん Vital Red ician: The lav certificate has ector, page 2.8	5								perfe 1 ☐ Yes	ormed?	death?	2 No
f Vita f Vita ysician: is certific director,	0	25. Was case referred to examiner?	medical					26. Place of Death				
of V Of V Physic rathis or ral dire		1 ☐ Yes 2 ☑ 1√No			atient 2 🗆	ER/Outpatien		4 LI Nursing Ho	me 5□Res	idence	6 ☐ Other (Spe	cify)
On of on of on of on of on of on of on of one of on	<u> </u>	27. Manner of Death 1 ☑ Natural 5 [Pending	28a. Date of (Month,	njury Day, Year)	28b. Time of Injury	28c. Injui Wor	ry at k?	28d. Describe	how inju	ry occurred	
isio ttendi death.	5	2 Accident	investigation Could not be					Yes 2 □ No				
Division of that or Attending Physics and after death. Ited in by the funeral direction of the physics of the p		4 ☐ Homicide	determined	28e. Place of	Injury - At ho etc. <i>(Specif</i>)	me, farm, stre /)	eet, factory, office		28f. Location (City or To	(Street ar wn, State	nd Number or R e)	ural Route Number,
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Divis To the Hospital or Atte within 24 hours after de within 24 hours after de completely filled in by the Medical Certific	3	(Check only 2	Medical Exan	niner: On the bas and manner	s of examinat	tion and/or in	estigation, in my	me, date and place, opinion, death occur	red at the time	, date an	s) and manner and place, and due	s stated. e to the cause(s)
To the within 2 to the comple		29b. Signature and title of	of certifier	and marries	stateu.		29c. Licens	se number		29d. Da	ate signed (Mont	th, Day, Year)
6 4 8 4		Ah	. 10	3 0.	S 14 .	110				-		
.0	-	30. Name and address o	f nerson who	completed cause	of death (Item	23a) (Time		377		De	c 4	, 2010
1~		Deneen Bowl						100	mn)	2122	G	
State		31. Date filed (Month, Da		82. Reg	istrar's Signat	ure	Baltim Val	01 (00		
Registrar		UEV (17 2011	Bener	U A.	par	Land of the same o					

			1- State of Maryland / Dep	partment of Health and I Prtificate of Death	Mental Hygieı Reg.	
	Physici		1. Decedent's Name (First, Middle, Last) Constance V. Roe		2. Date of Death Month November	29. 2010 9:30 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Prince George's Hospital	4b. City, Town, or Location of Death	1	4c. County of Death Prince George's
- 1	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 578—36—5676 1□ M 2图 F 81 Yrs.	Cheverly VI If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		ar) 9. Birthplace (State or Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
	he Mar	Director	Maryland Prince George's Riverda			1 ☐ Yes 2 🖾 No
	death with the Maryland ms 23a or 28a-f show r must be notified at		10e. Street and Number 6802 Beacon Place	10f. Zip Code 20737	10g.	Citizen of What Country? USA
350	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow or other traumatic event, the Medical Examinations.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces? 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced Year or Dates:		pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
212-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king	. Kind of Business/Industry
7	filed wil Hygien other th	е Соп	10 Hom	nemaker	ne (First, Middle, Maid	Own Home
land	Mental Mental Irked o	o Be	John Harvey Ingram		E. O'Donol	,
Mary	12 should be n and Mental 7 is marked or raumatic ev	Ī		ling Address (Street and Number or Ru		
e,	of Health Item 27 i		20a. Method of Disposition 20b. Place of Disposition	Mabank Lane, Bowing of the matory or other place)		15 Location - City or Town, State
DE I	Pages ment of tant: If it	١.,	TO DUTAL 2 ESCIPITATION 3 CITABILITY AT HOLL STATE		./2010 Ale	exandria, Virginia
Da	permit. Pages Department of Important: If any injury or once.			22. Name and Address of Facility Sasch's Funeral Hon	4; ne, P.A. Hy	739 Baltimore Avenue yattsville, MD 20781
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
ž	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ATFLE 03 (LENN) Due to (or as a consequence of):	CAMDIOUARWIAN	Disense	- years
	Examiner					
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Ď	ficate be executed physiclen and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
000	tificate g physi as the t	edical	d			
	To the Hospitel or Attending Physicien: The law requires thet the death certifulin 24 hours attended the state of the Funder death. To the Funderal Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
r (Spins)	uires thet signed b lid be deta		Part II. Other significant conditions contributing to death but not resulting in the Respuratory Failure Ventilator De	underlying cause given in Part I.	i	to use contribute to the cause of death?
	he law requir s has been sl ge 2 should	Completed by	AttakibiThation ADROZ ANEURYSE	(Exceptalopath		24b. Were autopsy findings available prior to completion of cause of death?
g	ian: T stiffcete ctor, pa	Be Co	Chronic Ubstructive Lung Disease 25. Was case referred to medicat examiner?		1 ☐ Yes 2 € 1 th (Check only one)	No 1 ☐ Yes 2 ☐ No
2 2	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2 and page 2.	ပ္	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatiet 27. Manner of Death 1	of 28c. Injury at	ome 5 Residence 28d. Describe how in	6 □Other (Specify) njury occurred
	tel or Atter rs after dea al Director ed in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	he Hospl in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Exeminer: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. (Date signed (Month, Day, Year)
	2		30. Name and address of person who/completed cause of death (Item 23a) (Type	DOISSZ Neprint) Nesbury Rd Hyat	DE	CEMBER 1, 2010
	Sta	10-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	NSBURY Rd Hyat.	truille M	18 20781
	Registr		DEC 0 7 2010 James B.	arked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 6:57 PM Hugh Gary Rohrbaugh December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 3, 1936 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ₺ M 2 🗆 F Country) Days Hours Yrs. **Director** 216-32-2588 74 Mar. Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1300 Unit D Sheridan Place 21015 and 2 should be filed within 72 hours after death ¹ Health and Mental Hygiene. tem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Deli Manager Grocery Store other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mark (nmn) Rohrbaugh Eleanor (nmn) Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21015 Marie Shine / Companion permit. Page 1 and : Department of Healt Important: If item 2 any injury or other t 1300 Unit D Sheridan Place, Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Laburiai 2 Li Cremation 3 Removal fro m State Trinity Lutheran Cem. 12/6/2010 Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doth Months Immediate Cause (Final severe aortic stenosis Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 weeks if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Urosepsis Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Certificate: To Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signature and title of certifier

MICHAL.
31. Date filed (Month, Day,

mm

Pitzer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

102

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32. Registrar's signatu

Wolfe

DHMH 17 Rev 7/2009

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MD

Balt imore,

December 2, 2010

			for State Registrar	Otate of Ivial	-	ertificate of			g. No.	38221
П	Physicia	an	Decedent's Name (First, Middle, Last		ROSENBI	ERC		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al			ROBEND				4, 2010	1:29 A M
	Examin	er	4a. Facility Name (If not institution, give 3200 N. Leisure W		#219		or Location of Death er Spring		Montgome	
~	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
ь	Director		5//-44-1089	X M 2□F	82 Yrs	Months Days	Hours Will.	July 4,		ington, DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location				10d. Inside City Limits
	Mary Ff sh	tor	Maryland Montgom	ery		Silver	Spring			1 ☐ Yes 2 📉 No
	or 288	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath wi	ral	3200 N. Leisure Wo			209			United Stat	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be northed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cult1 □ Yes 2 □ No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: wt	
2-0	72 ho	etec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	1 (6	ecedent's Usual Occu	during most of work	ing 1	6b. Kind of Business/li	ndustry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retire	,		701-	
д 5	filed v Hygid other ent, II	Be Co	17. Father's Name (First, Middle, Last)	4		Pharmacist		e (First, Middle, M	Pharmacy Jaiden Surname)	<u></u>
Maryland	uld be f Aental rked o	To B	William Rosenbe	erg			Molli	e Shuster	r	
ary	should and Men is marke		19a. Informant's Name/Relationship (T	*					City or Town, State, Z	
o`	and and must must be must be true true must be true true must be must		Renee Forcier, Wi	îfe						er Spring, M
altimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,)			Gardens 1:	2/06/10	Oc. Location - City or T	own, State
Ba	permi Depar Impor any ir		21. Signal are of Funer (15) in a Line	6111	800	Torchinsk	ess of Facility Y Hebrew	Funeral H	Home	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		254 Carro enter the mode of dy	11 St., W	W. Washir or respiratory arre	igton, DC	Approximate Interval Between Onset and Death Smooths
68760,0	icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerping Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):				ν.	
687	tificate ng phys as the	Aedical		d				12.12		
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within Ext hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date of deli Month	very Day Year
ď.	s that ined b e deta	by Ph	Part II. Other significant conditions co	ntributing to death but		, •	iven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w requires that s been signed t should be deta		Prostate CAN	cer	Hyper	tension		1 ☐ Yes	s 2□No 3 🗖 Pro	bably 4 🗌 Unknown
Records,	: The law recate has be page 2 sho	Completed	Color CANCE		Neur	opathy		24a. Was an autopsy perform 1 ∐Yes 2	prior to c	opsy findings available ompletion of cause of
ā	siclan; The certificate rector, pagr	Be C	25. Was case referred to medical			921 75		h (Check only one)	2 12%
5	Physic this or		1 Yes 2 No			atient 3 DOA Ot	ther: 4 Nursing Ho	ome 5 Resider	nce 6 □Other (Spec	rify)
Division of Vital	Attending F death. ctor: After y the funera	cation:	27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day,)	Year) 28b. Tim Inju	ry Wo	ury at ork? □Yes 2□No	28d. Describe how	w injury occurred	
Ω	spital or Attend ours after death reral Director: . filled in by the f	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm (Specify)	, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical		rsician: To the best of iner: On the basis of e and manner state	xamination and/					
	To the Comp	M	29b. Signature and title of certifier	5.11			nse number		d. Date signed (Month	
			C/Sanits	-) Sull	m)		39190	ì)ecember	6,2010
	30		7 7 7 7 7 7 7 7	ompleted cause of dea M.D. 3418	th (Item 23a) (Ty Dland	word Ct.,	Suite III,	Olney,	MD 208:	32
I.	Sta Registr		31. Date filed (Month, Day, Year)	#1 32. Hedistrar:	s Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. The Phys 10c, fs19b, Per FH C910, 12/09/10 Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30. 2010 November 3:50 AM Patricia Ann Reynolds Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, Checkin Chase 4c. County of Death Bethesda Montgomery 4407 Leland Street Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Feb. 27, 1961 1 □ M 2 🏻 F Months Days Hours Pennsylvania 49 **Director** 187-38-8233 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 X No Chevy Chase Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? Funeral 23a 20815 United States 4407 Leland Street 20814 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) International Agency 5+ Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o ၉ Gilmer Reynolds Jean Drager item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurgh Route Number, City or Town, State, Zip Code) 4407 Leland Street, Bethesda, Maryland 20814 Daniel Robert Vincent/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State December 5, permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Hauon non M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Ph sician/ a. Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Dause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the and be detached for 1 Yes 2 L 9 Unknown Unknown Hospital or Attending Physician; The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l autopsy performed 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction 1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 30, 2010 M032864 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #1125, Chevy Chase, Maryland 20815 Fishman, M.D., 31. Date filed (Month. Dav. Year) 32. Registrar's Signat State DEC 07 Darke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:30 P ^M Norma B. Smith 2010 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Envoy Of Pikesville Nursing & Rehab Pikesville 8. Date of Birth (Month, Day, Feb 9, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 1 □ M 2 📉 F 79 Yrs. 216-28-9254 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Iften 27 Is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Gwynn Oak Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 **USA** 3667 Forest Garden Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 🏋 No Specify ģ 3€ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Activities Director Assisted Living 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Edlestein Joseph Einhorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3667 Forest Garden Avenue Gwynn Oak, MD 21207 Richard Smith, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/07/10 4 Donation 5 Dother (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Momas tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed peen Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No cate has l certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: 1 Natural
2 Accident To the Hospital or Attending Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director; A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0 State

Registrar

29b. Signature, and title of certifier

31. Date filed (Month, Day, Year)

Black

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MB

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\$2. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

29c. License number

20061199

29d. Date signed (Month, Day, Year)

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10-09168 William Svricek, Jr

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Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Theodon M.	Tung J	K.	en.D,	0.0	.M.E. 0	VIVIL	No	vember 30,	2010
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LIAM Month Day -50 AM 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death columbia Owase 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Sex 1XXM 2 □ F **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign March 5, 1932 Months Days Hours Director 217-28-8738 78 Washington, DC Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Elkridge 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6503 Vert Drive 21075-6656 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea Elementary/Seconday (0-12)
Grade 5 College (1-4 or 5+) Floor Mechanic Remodeling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William K. Stivers Caroline E. Harmon 19a. Informant's Name/Relationship (Type, Print) Ruth Stivers spouse 6503 Vert Drive Elkridge, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X urial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 12/7/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee ²²Donaldson Fulleral Home, P.A. 313 Talbott Avenue Laurel, Maryland / M00770 20707 23a. Part 1. Enter the disease, shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner level offrigor Sequentially list conditions, Examine it any, reading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ohn Henry 11/29/2010 6:45 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 🖾 M 2 🗆 F Months Hours Min. (Month, Day,) Oct • 27 1957 Washington, DC Director 579-84-6448 53 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20740 5903 Bryn Mawr Road USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ٥ \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Floral Wholesale Florist or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Monalee Robinson John Henry Shuey, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5903 Bryn Mawr Road, College Park, MD 20740 Kimberly L. Shuey / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12/6/10 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and s the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical P,O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the a ld be detached f 2 🗌 No 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? this certificate 1 Yes 2 No Yes 2 To 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 2 No 1 Yes မှ hin 24 hours after death.

the Funeral Director: After this on the funeral director is the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury 1 Matural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death pocurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number rectioner: To the best of my knowledge. Seath continued at the films, path or opinion, death or of as a form. 101 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1) 0060339 29

State Registrar Khalid H. Ashai, 7525 Greenway Center Drive, Suite 313, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year Month DECEMBER 3:15 P M MAXINE ZOLA STOKER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Min. 1 🗆 M 2 🖫 F Hours Director 218-38-3857 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Harford Darlington Marvland 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 2 23a Funeral USA 21034 2207 Shuresville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry oe filed wn... rtal Hygiene. Ser than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker should be filed with and Mental Hygien ris marked other to Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumations မ Elizabeth (nmn) Baker James Eli Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 308 North Paradise Road, Havre de Grace, Maryland 19a. Informant's Name/Relationship (Type, Print) Sandra E. Kave / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 12-8-10 Bel Air, Maryland McConas Funeral Home, P.A. MD 21014 50 West Broadway, Bel Air, 23a. Fart 1. Enter the disease, or compleating shock, or heart failure. List only one car es that caused the Approximate Interval Between Onset and Death Immediate Cause (Final ESPIRATORY Ph_sician/ disease or condition Medical resulting in death) OBSTRUCTUR PULMONARY DISEASE Examiner EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Yes 2 1 ☐ Yes 2 ☐ No 968660000 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 🗹 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it work? 1 Natural 5 Pending 2 🗆 No 2 Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my knowledge death or mind at the limit cell and damped at the causele, and manner as stated. (Check J. Wursel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DECEMBER 4, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) hesapeake Dr Bulair, md 21014 tatric 31. Date filed (Month, Day, Year) 32. Registrar's Signatur DEC 0 Registrar

121007

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38228 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barbara A. Sullivan November 30, 2:45 P 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏋 F Days Months 77 February 18, 1933 Washington, D.C 725-07-9113 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery 1 Tes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 N. Leisure World Blvd. #106 20906 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Georgetown Elementary/Seconday (0-12) College (1-4 or 5+) Employee Education University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Leo Sullivan Ellen Keane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906Richard Sullivan/Brother 15107 Interlachen Drive, #411, Silver Spring, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State December 4, 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01498 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ovarian Cancer Due to (or as a consequence of): Bowel Perforation Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3

Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year

Physician/ Medical **⊌Examiner**

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After this certificate

hours after death

within 24 hours a To the Funeral L Hospital

filled in by the funeral director,

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Medical

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or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Physician/

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Funeral

Director

or 28a-f show notified at

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and Mental Hygie is marked other

Department of Health and Mental H Important: If Item 27 is marked ott any injury or other transmissiones.

72 hours after death

Baltimore, Maryland 21215-0036

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Director

Funeral

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Examine Physician/Medical Completed by Be ၉ Certificate:

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🖺 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of

28a. Date of injury (Month, Day, Year) 1 X Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be

determined

28c. Injury at work? 28d. Describe how injury occurred 1 Yes 2 No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

December 2, 2010

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my providing of eath occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Time out of my could go do the crime of the firm, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kashif Firozvi, MD 2101 Medical Park Drive, #200, Silver Spring, Maryland 20902

D0064983

State Registrar 31. Date filed (Month, Day, Year, 32. Registraris Signature DEC 07 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Physician/ 1503 м JOSEPH Ν. SEIMAH ECEMBER 201Medical 4c. County of Death
MONTGOMERY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 ☐ F **Funeral** 41/01/15 P/1/1993 7 Hours 73 Yrs. 126-52-2590 **Director** TRERIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland Director r 28a-f sl notified 1 X Yes 2 ☐ No NEW CARROLLTON PRINCE GEORGE' MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 ral", or items 23a o Examiner must be Funeral UNITED STATES 20784 6117 84th AVE Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK "natural" Completed 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natu
other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) POLICE OFFICER PRIVATE 2yrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FORKPA DUOR ပ CHIEF NARMAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6117 84th AVE NEW CARROLLTON, MD., <u>JOSEPH N. SEIM</u>AH <u>J</u>R./SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth GATE OF HEAVEN CE 12/18/10 SILVER SPRING 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify Signat e Funeral Service Lice 22. Name and Address of Facility CAPITOL MORTUARY 20002 NE WASHINGTON MARYLAND AVE. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nilyone cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Saguartially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 M No ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner Jahr Certificate: 5 \square Pending atural 1 🗌 Yes 2 🗀 No Μ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License numbe who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		2	20a. Method of Disposition 1 Burial 2 Cremation			20b. P	Place of Dispo emetery, cren	sition (Nai natory or d	me of other place)		Da	nte	20c. l	ocation - City or T	own, State	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:26AM 2010 December Seaborn, Sr. Physician/ Morris Chester Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Examiner Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) . Social Security Number Months Days **Funeral** DC 1**X** M 2 □ F 79 579-36-8691 Director Usual Residence of Decedent Usua. 10a. State SC 10d. Inside City Limits 10c. City, Town or Location or 28a-f show Garden City iral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No Horry 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29576 846 Mast Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Specify: White 1 Yes 2 No Specify: 21215-0036 3 XWidowed 4 Divorced "natural", Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Transportation <u> Vice President</u> 10 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland D. Cage Margaret ည Seaborn Sencie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Patricia L. Milliken 710 Bald Eagle Lane, Lusby, MD 20657 Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12/7/2010 Woodbine, MD Final Journey Crem. 21. Signature of Funeral Service Licensee Dorpta Marshall

22. Name and Address of Facility

Maryland Cremation Services

PO Box 1413, Raltimore, MD.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) 21. Signature of Funeral Service Licensee Dorpta Marshall 21203 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ restante Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna5 Other (specify) Dav Month in the past 12 months? Pregnant Pregnant at time of death 2 No ed by the a detached fi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 res 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 has after death.

Director: After this certificate I
I in by the funeral director, pag 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nersing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 🗌 Yes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 5 Pending 1 Natural 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be completed filled in by 4 Homicide determined Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

14+1

Registrar

DHMH 17 Rev 7/2009

Frederickimo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrates Signature

Road

100 Huspital

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dece (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OR -HWESTN Baltimore N/A Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F 162-40-8975 Months 61 Hours Director Dec. 23 Year) 1948 Yre Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severn 1 ☐ Yes 2 X No 23a or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8263 Sebring Court 21144 United States · items should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ò þ Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. "natural", 3 Divorced 4 XDivorced White Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than, Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha College (1-4 or 5+) Medical Transcriptionist Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Edward Tracy Clara Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Tracy / Son 8263 Sebring Ct., Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc permit. Page 1 a
Department of h
Important: If ite 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/6/2010 Baltimore, Maryland Signature of Funeral Service Licensee ALVSON K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on last line. Approximate Interval Between Immediate Cause (Final Onset and Deat Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): signed by the attending physician at the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tonknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 WNo ျ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury ☐ Accident☐ Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 1004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 METUNIZ 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar

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	State of Maryland / Department of He	

2010 3823	,
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		For State Certificate of Death		Reg. 1	No.	, , , , , , , , , , , , , , , , , , , ,
Physician/	_	Decedent's Name (First, Middle,Last)	Mo	te of Death onth Da	ay Year	3. Time of Death
Medical Examine	r	Elana D. lune	De	cember 2,	2010	2020 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Do	eath		4c. County of Dea	ath A
· ·		3800 West Belvedere Avenue Apt. 314 Baltimore			/V/2	†
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Min	oate of Birth (N		Birthplace (State or Foreign Country)
	2	sual Residence of Decedent		ane.ie	SITPI	1114
fu a		Oa. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ı	Md N/A Raltimore				1 Yes 2 No
15 nryland Sa-f sho at once	-	Oe. Street and Number		10g.	Citizen of What Co	ountry?
74/5 the Maryland a or 28a-f sh tiffed at once Director	1	De Street and Number			1166	1
17415 with the Maryland as 23a or 28a-f sho be notified at once.		1. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify	Yes or No-	14. Race - Am	erican Indian, Black,
r death with not it is not be no		Married Armed Forces? If Yes, specify Cuban, Mexican, Pu	erto Rican	, etc.)	White, etc.	
er de		1 Yes 2 No No specify:			Specify: D	lack
rs aft	Ր -	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		one 16	b. Kind of Busines	ss/Industry
5-0036 ed within 72 hour lygiene. other than "nate the Medical Exa	}	Elementary/Secondary (0-12) College (1-4 or 5+)	e retired)			
36 bin 7: than		12 A Receptionist		<	Speial Se	rvice Agency
d with	┋┝	7. Father's Name (First, Middle, Last)	lame (First	, Middle, Mai	den Surname)	9
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D 21215-(should be filed v and Mental Hyg 7 is marked oth natic event, the		9a. Informant's Name/Relationship (Type, Print) (Father) 19b. Mailing Address (Street and Number	r or Rural E	Route Numbe	r, City or Town, Sta	ate, Zip Code) 21,215
MD 12 shouth and the and the and time at the sum at the		Mr Lawrence Tune 3315 Liberty H	teiah	ts A	Ve.D2 B	alto.Md.
2 2 2 2		20a. Method of Disposition (Name of cemetery, crematory or other place)	Date	2	0c. Location - City	or Town, State
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	2	4 Donation 5 Other Specify VVVVVVVVVVVVVVVVVVVVVVVVVVVVVVVVVVVV		11	1	1
Balti permit. Depart Import injury		Vanse Stan Joseph L. Kuss	Ave.	eral r	tome for	21216
Physician	12	3a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	liac or resp	iratory arrest,	, shock, or heart	Approximate Interval Between Onset and
Medical	J.	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (fentany1 and morphine)) and	cocai	ne intox	
Examiner		or condition resulting in death) Due to (or as a consequence of):				
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		fary, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				-3"
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of Brant neral	-1	27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work?		_	w injury occurred	
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/iSi rr Att rer de rirect n by	<u> </u>	3 Suicide 6 A Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f.	Location (Stroor Town, State	eet and Number or te) 3800 W.	Rural Route Number, City Belvedere AV
urs af	Certification:	4 Homicide determined (Specify) Found: residence	Ap	t 314	Baltimor	Belvedere Av e, MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only	e, and due t	to the cause(s) and manner as	stated.
o the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the			
F 3 F 8	Σ	29b. Signature and title of certifier 29c. License number			29d. Date signed (
		O.C.M.E.			December 3, 2	2010
d	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
φ		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201			
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Registr		DEC 6 7 2010 8		_		

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Cocaine use 1 yes 2 No 3 Probably 4 Unknown	Sox 6876 leath certificat e attending phy for use as the	/sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ot		ancy		ay Year
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10-09221	
Keith Tyler	

\eith Tyler	1- For State Registrar		epartment of l			2010	38235		
Physician/ Medical Examiner	Decedent's Name (First, Middle, L KEITH	_ast)	TYL	'R	2, Date of De Month Decembe	ath Day Year er 1, 2010	3. Time of Death 1137 hrs		
()	4a. Facility Name (if not institution, Johns Hopkins Bayview		4b	City, Town, or Location		4c. County of Dea	ath		
Funeral			yrs. last birthday)		der 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. E	Birthplace (State or		
Director	216-72-7919	X _{M 2} F 51	· Yrs.	Months Days Hour	o4/1	9/1959 Fore	eign Country) MD		
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	MD		BALTIMO	RE	_		1 XYes 2 No		
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number			Of. Zip Code		10g. Citizen of What Co	untry?		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1 X Burial 2 Cremation		Ob. Place of Disposition crematory or other	n (Name of cemetery,	Date	20c. Location - City of	or Town, State		
Baltimore, Peemit. Pages 1 ar Pepartment of Her Important: If ite	4 Donation 5 Other Spece 21. Signature of Funeral Service Lice		DRUID RID			BALTIMORE	NS F.H.,INC		
Ba Permi Depa Impo injur	Lames a	Morton				., MD 21213			
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inten								
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Due to (or as a consequent		lerotic car	diovasculai	disease	Death		
_	Sequentially list conditions, if any leading to immediate	b. Due to jor as a consequent	ce off:						
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C. (Disease or injury that initiated Due to (or as a consequence of):								
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x 6876 h certificat tending phy use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	2 Fetal	death 3 Ectopi	c pregnancy	23d. Date of delive Month	ry Day Year		
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of Vital Records, ig Physician: The law requir ther this certificate has been sherel director, page 2 should 1: To Be Completed			autopsy perform <u>ed</u> ?						
ital Relician: The scrifficate rector, page	25. Was case referred to medical examiner?	Unanieli —		26 Place of Death		2 No 1 Y	es 2 No		
n of Vii ding Physic hater this funeral dir	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	✓ ER/Outpatient 3 28b. Time of Inju-			Residence 6 Othe	er:		
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Division o spital or Attending ours after Jurector: Aft neral Director: Aft filled in by the func	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rur or Town, State)								
	29a. Certifier 1 Certifying Phys	Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the Hos within 24 h To the Fur completely	one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
2	29b Signature and title of certifier	-D/26 38	200	29c. License number O.C.M.E.		29d. Date signed (Mo December 2, 20			
0.0	30. Name and address of person who completed cause of death (Item 23a)								
, true		Assistant Medical Exa		n Street, Baltimore	e, MD 21201				
State Registrar		32. Registrar's Sig	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. last birthday Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🛛 F -92-006 July or Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinator must be notified at 1 Nes 2 No altimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 2 100 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ₩o Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountan marce 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be aron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) rolyn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Neurial 2 ☐ Cremation 3 ☐ Removal from State altimore 2010 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ischemic Stroke **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Ye ar Month Day 5 Other (specify) ed by the a ∃Yes 2 No P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No has e Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate h. 1 ☐ Yes 2 🗌 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler RES - 000 December 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOIFE St, BALTIMORE, MD 21287 Wingate Jamie 31. Date filed (Month, Day, Year) 32. Registrar's Signature fack Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 Gerard Ignatius Umerley, Sr 3:10 A December Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 712 S. Fountain Green Road Bel Air Harford 8. Date of Birth (Month, Day, Year) April 1 . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🕱 M 2 🗆 F Months Min. 1936 Maryland Hours 218-32-5737 **Director** 74 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 712 S. Fountain Green ROad 21015 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces ò 1 Never Married 2 Married "natural", or Yes 2 No filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3℃Widowed 4 □ Divorced Completed Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Trucking 12 of the and Mental Hygier 27 is marked other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should be nent of Health and Ments Ignatius Umerley Helen Scovern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Gerard I. Umerley, Jr. / Son 712 S. Fountain Green Rd. Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 6, 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Highview Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2010 Fallston, Maryland Funeral Service bicensee Evans Funeral CHapel & Cremation Service-BelAir Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Onset and Beath Immediate Cause (Final ancer Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner il any, leading to infraediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a donactionos of: as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical requires that the death certificate be attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 2 No the the funeral director, page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes Be (Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? O No Hospital 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending injury work? after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) le combon 3 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Patricia inci Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Hos Baltimore Cit Harbor pital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday, 8. Date of Birth 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Months Hours Ma^{(yon}Tro^{ay}1^y938 MaryTand Director 212-36-2053 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Examiner must be notified at Director Baltimore City Maryland 1 XYes 2 No 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral 23a 21230 1926 Deering Ave. United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any ijury or other traumatic event, the Medical Examiner mus any incry or other traumatic event, the Medical Examiner mus any incry or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married 2 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Calvert Drug Company Secretery 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Agnes Gallagher Robinson James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1926 Deering Ave., Baltimore, Maryland 21230 19a. Informant's Name/Relationship (Type, Print) Peter Joseph Vinci/ Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Meadowridge Mem. Park Dec. 6,2010 Elkridge, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) AMBROSE FUNERALY HOME OF LANSDOWNE Signature of Funeral Service Licenses 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 alline 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final respirator Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner neumonia that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year signed by the atte in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Records, funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 N 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Minpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hornoves

DHMH 17 Rev 7/2009

State Registrar 10-09371 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Octavia Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day December 2, 2010 **Medical Examiner** 0000 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1117 Cummings Avenue Catonsville **Baltimore County** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 No Pages I and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", o 3 Widowed 4 Divorced If Yes. Give Year 1 Yes 2 No specify: other than "natural", Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) (Lite Partner cs l and and of the state of th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9 12010 Department of 4 Donation 5 Other Specify e Sign store of Funeral Service Line 22. Name and Address of Facility Joseph L Home dysser Each 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Medical Narcotic (Heroin) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi Physician/Medical AMENDED 23a,27,28a-f,per ME g910 12/21/10 TT X UNPENDED The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Completed Records, 24a Wasan autopsy certificate has ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 No 5 Pending death. the Fd 12/2/10 unk 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc.

9. Birthplace (State or Foreign 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian, Black 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 (22 & 20c. Location - City or Town, State Approximate Interval Between Onset and Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of Hospital or Atteodiog Physiciao: Other | Nursing Home 5 Residence 6 Other: Scene Division Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 117 Cummings Ave Catonsville, MD filled in by 6 Could not be 3 Suicide (Specify) Found: residence determined Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 7, 2010 borland 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

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		State Registrar	Reg. No.							
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Funera		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 i		h 9. E	Birthplace (State or Foreign		
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or 28;	Director	MD Baltimore 10e. Street and Number	Reiste	10f. Zip Code			10g. Citizen of What (
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eath v tems	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S. 13. V			(Specify Yes or No- uerto Rican, etc.)	- 1 -	nerican Indian,		
fter d	<u>۾</u>	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give	No II			uerto Rican, etc.)	Black, Wh	ite, etc.		
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filed wall Hyging of other	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,		, , , , , , , , , , , , , , , , , , ,		
//an	은	Arthur J. Watkins				Willa Ma				
Maryland 2 2 should be filed wi th and Mental Hygie 27 is marked other traumatic event, ti		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or	Rural Route Number	; City or Town, State, 2	Zip Code)		
nd mag		Alice M. Watkins Wife				Reistersto	wn, MD 21	136		
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other ance.		20a. Method of Disposition 1 ◯XBurial 2 ◯ Cremation 3 ◯ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	ө)	Date	20c. Location - City	or Town, State		
timo t. Page tment o tant: If		4 Donation 5 Other (Specify)	Garrison 1	Forest Ve	t	12/10/10		Mills, MD		
Baltimore permit. Page 1 a Department of H Important: If ite any injury or ott once.		21. Signature of funeral Service to usee J. Wayne Ost	orling	. Name and Addres			4 Reisters			
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- Physical admini		shock, or heart failure. List only one cause on each line Immediate Cause (Final	. I location borner	i the mode of dying	g, addir as care	nac or respiratory and	551,	Approximate Interval Between Onset and Death		
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BOX death c te atten ed for u	iciar	IF FEMALE: 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Y 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Y 1 Yes 2 No 9 Unknown 9 U								
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aw re as be 2 shr	1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 3 Probably 4									
1 Yes 2 No 3 Probably 24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 3 Probably 24b. Were autopsy find prior to completion death? 1 Yes 2 No 1 Yes 2 No 2 No 3 Probably 25c. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 26c. Place of Death (Check only one)										
Ital ician: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:				Check only one)				
OT V ig Phys er this oneral dir	은	1 Yes 2 No 1 Pospital 1 Popular 27. Manner of Death 28a. Date of injur	nt 2 ER/Outpatient y 28b. Time of		4 ☐ Nursin		ence 6 Other (Spe	ecify)		
ding th. After fune	Certificate:	1 Natural 5 Pending (Month, Day, 2 Accident Investigation		28c. Injury work? M 1 🗆 N	aτ Yes 2. □ No	28d, Describe no	ow injury occurred			
VISION or Attendin fler death. irector: Aff	Ę	3 Suicide 6 Could not be 28e. Place of Inju	y - At home, farm, stre			28f. Location (St	treet and Number or R	ural Route Number,		
talor s afte al Dire		building, etc.	(Specify)			City or Town	n, State)			
tospir 4 hour unera ed fille	edical	29a. Certifier 1 Certifying Physician: To the best of r (Check 2 Medical Examiner: On the basis of ex	ny knowledge, death or	ccured at the time,	date and place	e, and due to the cau	se(s) and manner as s	tated.		
thin 2.	Me	only one) 3 Certifying Nurse Practioner: To the b	est of my knowledge, de	eath occurred at the	time, date and	place, and due to the	cause(s) and manner a	s stated.		
6.≱ 6.8		29b. Signatura and title of bertifier		29c. License			29d. Date signed (Mon			
		20 Name and Shape of parent who	ath (Itam 22-) T	1000	6332	-	11,30,0	2010		
1+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAN DEEP JINGH 200 Memorial Ave. Westminster MD21157								
Sta	te	31. Date filed (Month, Day, Year) 32. Registral		Car / IV	· · · · · · · · · · · · · · · · · · ·	Crock	r-twort v			
Registr		NFC 07 2010 Pages > B.	barker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Catherine G. Wellein 02:00 PM December 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore n/a Agnes Hospita 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 82 219-22-4120 Director 12/5/1927 Maryland Usual Residence of Decedent 10b. County 10c City Town or Location show 10a State 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be nothered Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Linthicum 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21090 626 North Hammonds Ferry Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No White ð Specify Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker and Mental Hygie Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Eichelman ည Christine Schrufer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 s nt of Health an Jean D. Somers / Daughter 132 Carroll Drive, Annapolis, Maryland 21403 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or Donation 5 Other (Specify) Meadowridge Mem. Pk. 12/6/2010 Elkridge, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signature of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' certificate 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physiclan: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical P23613 December 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) halise Baltimore Nath 900 Caton 2122 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22 11:57 A M 2010 Beatrice Annette Wilson November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore 431 Notre Dame Lane If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 216-42-6571 1 M 2 F 66 Director 11 6.43 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **Baltimore** 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it wheten Examiner must be notified at MD MD N/A lane, Bello, 49.21212 Yes 2□No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 431 Notre Dam Ln. # 204 21212 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black White, etc. 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpeciaBlack þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Lane Annette Elkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. Jaqualyn Brown/Daughter Jacqueline 12323 Clouzburt Moreno Valley, CA 92555 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/1/10 Final Journey Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charisse N. Woods 2700 Edmondson Ave. Balto., MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic Carlie V mules de disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Remelarlery structis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been sig ; page 2 should b Completed peripheral vis discuse 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 □Yes 2 □No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manur of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 ☐ Homicide 24 hours a Medical 29a. Certifier 1 Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28266 11/26/10 30. Name and ardress of person who completed cause of death (Item 23a) (Type, Print) Ayelwin. no. 5010. YURK Rt, Balto, MS. 21212 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, per INF, G910.12/9/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 Wantinee Buapun Wasmuth 2:20 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Y August 11, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Thailand **Funeral** Sex 1 □ M 2 🛛 F Months Days Hours Min 72 Yrs Director 577-80-7984 1938 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Tes 2 X No Maryland Montgomery Silver Spring Street and Number 10f. Zip Code 10g. Citizen of What Country? 10213 Day Avenue U<u>nited States</u> 20910 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked others any injury or others. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed Specify: Asian 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Keypunch Operator Hote1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Inton Buapun Braung Parnthong 19a. Informant's Name/Relatiopship (Type, Print) Jurgen G. O. Wasmuth/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jurgun Wasmuth/Husband 10213 Day Avenue, Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State December 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Be<u>thesda</u>, Maryland Robert A. Fumphrey Funeral Home, Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Lice M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Atheroslcerotic Cardiovascular Disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Progressive Supranuclear Palsy 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha irector, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury Investigation M Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) 35 a December 3, 2010 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Raymond White, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Robert December 1:50 Langdon Woods Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Health and Rehabilitation Center <u>Bethesda</u> Montgomery 8. Date of Birth
(Month, Day, Year)
December 13, Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Connecticut Director 88 396-16-0616 1921 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3535 Chevy Chase Lake Drive #210 20815 United States 2 should be filed within 72 hours after death v th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specification, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 √ Yes 2 □ No If Yes, Give ↓ Year or Dates. Specify: White 1 ☐ Yes 2 No Specify. WW II 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) RealEstate Mortgage Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. 7 is mark ည John C. Woods May Langdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra 12011 Stuart Ridge Drive Herndon, Virginia 20170 C. Woods / Daughter Maureen 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State December 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6, 2010 Bethesda, Maryland 21. Signature of Funeral Service License Robert Addres Puffightrey Funeral Home Bethesda-Chevy Chase, Inc. M01607 7557 Wisconsin Avenue Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ MENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💋 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? Yes 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2**/2** No 1 🗌 Yes ၉ 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending i 24 hours after death. E Funeral Director: At leted filled in by the fu 1 Yes Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hor To the Fune completed fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

31. Date filed (Month, Day, Year) **DEC 0 7 2010**

641

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, M.D. 10110 Molecular Drive #206 Rockville, Maryland 20850

a Revery D

32. Registra s Signature

00057124

12/2/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 per dr.,g910,12/07/2010dhb.

Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) Helen M. Wenzing 2. Date of Death Physician/ Month Day 🧳 5:15AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 21784 Gaither SYNCESVILE, MI uno . Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Sept 22 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last birthday) **Funeral** Year) 1911 Hours Min. 1 □ M 2 🕅 F Maryland 99 Director 214-12-1855 Sept Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a edical Examiner must be Funeral 7426 Gaither Road 21784 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", any injury or other traumatic event, the Mee. once. is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Henry Mullenberg Virginia Lee Doudiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Evans/daughter 504 Hemingway Drive Bel Air, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Signature of Funeral Service State Anatomy Board 655 W. Baltimore Street Dixector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line, Approximate Interval Between Inset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): -Examiner Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, signed by the attending physician and deed betached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes been : 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s after death.

Director: After this certificate has I din by the funeral director, page 2 s performe 1 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 33681 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD SUITE 114

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

1380

32 Registrar's Signature

PROGRESS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley WISOTSKY Month 2010 10:30 P ^M D<u>ecember</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9108 S. Chamberlain Lane **Owings** Calvert 7. Age (In yrs. last birthday, 74 Yrs. If Under 1 Year 9. Birthplace (State or Foreign **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2 □ (F 578-46-0411 Months Days (Month, Day, Y Hours Virginia Director Jan 1936 Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Virginia Fairfax Fairfax 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 4412 Jensen Place 22032 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. ģ ☐ Yes 2 🕅 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced Completed Specify: and Mental Hygiene.
is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fairfax County Elementary/Seconday (0-12) College (1-4 or 5+) Volunteer permit. Page 1 and 2 should be filed will Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, If once. <u>Library</u> Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christine Carter 2 Seager Fagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9108 S. Chamberlain Lane, Owings, MD Wayne Reed, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/05/10 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Furnal Levice Licenses Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death WEEKS Immediate Cause (Final Physician/ a Acute Cererovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 No g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Carcinoma of the lung Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate performed?

☐ Yes 2 🗓 No 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မြ 1 🗌 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Son's Home 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)
December 3, 2010 29c. License number D19431 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Frank M. Ryan, MD 11701 Livingston Rd. #103, Ft. Washington, MD 20744 12 31. Date filed (Month, Day, Year, 92. Registrar's Signature State Registrar Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#8, 18perffl, G915, 5/10/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Zanne Vovemo Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death timore 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign Country) Washington DC 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Hours **Director** 214-96-8680 40 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 No Maryland | Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral 12800 Lamp Post La. USA 20854 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Salesz Pharmaceutical Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Page 1 and 2 should be ment of Health and Menta Elie Assaraf Doddy Nahmani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other the once. #102 Rockville MD 20852 Samy Ymar / Friend 1410 Strand Dr. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State on Cemetery

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20. Variety of Facility 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 11/05/2010 Lebanon Cemetery 21. Signature of Funeral Service Licenses l Direction Inc Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Pulmonary Embolism Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown rate has been signed by the page 2 should be detached <u>P</u> 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 은 1 Phpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending worl 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be filled in by the Sulcide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Merci State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔀 📗 📗 1 - State AMEND#24a/boerMD,11/18/10,BW,MCO Registrar AMEND #19-poerFH,11/18/10,BW,MCO Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:05 A M 11 Bahman Ahaneen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital
Social Security Number 6 Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthpia Country) Iran **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖳 M 2 🗆 F (Month, Day, Yea 2/10/1929 454-51-2740 81 Director Yrs. Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Potomac 1 Yes 2 No rms 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10714 Potomac Tennis Lane an "natural", or items Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+ Embassador State Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Effat Sephanlou Hosseingholi Ahaneen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Minoo Ahaneen (wife) 11801 Rockville Pike #805, N. Bethesda, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 11/12/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 21. Signature Funeral Service Court 22. Name and Address of Facility M0155 National Funeral Home 7482 Lee Hwy., Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Fitysician/ disease or condition resulting in death) Sinus Brady Cardia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, e attending physician and for use as the burial-transit if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending Pi 24 hours after death.
 Funeral Director: After the Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral Completed filled in the Funeral Completed filled filled in the Funeral Completed fill 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 11/7/10 D67986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) State Registrar

707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PATRICIA B. ARCHES 6:27M Novembe Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Hours (Month, Day, Year) 1 . M 2 . F <u>Hadensvilly</u>A Director 231-48-1620 73 /1/1937 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 21921 USA 25 Park Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 😾 Married þ 1 Yes 2 YNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Divorced Completed Year or Dates marked other than "natur matic event, the Medical I 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic/Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 rmit. Page 1 and 2 should be f partment of Health and Menta portant: If item 27 is marked y injury or other traumatic e Jack Schools Evelyn Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 493 Pond Neck Road, Earleville, MD 21919 Diane Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Townsend Cemetery 11/16/2010 Townsend, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad Street, Middleterm appropriations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approvinta@9 Interval Between 23a. Part 1. Enter the disease shock, or heart failure. Li nset and Death Immediate Cause (Final Pnysician/ mknown disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and Due to (or as a consequence of) resulting in death) Last physician the burial Hospital or Attending Physician: The law requires that the death certificate be to hours after death.

Funeral Director: After this certificate has been signed by the attending physicians the filled in by the funeral director, page 2 should be detached for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No ☐ Yes 2 🗷 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 🖳 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D0023322 11.12.2010. 1 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 AE High ST Elhten MD 21921

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician VOV 2010 ARGARET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ROAD CHESTERTOWN SHORE QUEEN RIVER If Under 1 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1□M 2**X**F 120569 MARCH 3, 1913 Director 70 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 No MD CHESTERTOWN QUEEN traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e Street and Number Ö SHURK ROAD USA 21620 RIVER 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates; Race - American Indian, Black, White, etc. or items, 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ESTATE BROKER 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ATHLEEN 19a. Informant's Name/Relationship (Type. Print) \$150 Descriptor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau ANTHON KNOX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Fown, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 Cremation 3 ☐Removal from State CHESAPEAKE CREMAIN 11/5/2010 LHESTER 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Licensee MO DIRECT 205 CREEN HEREN WAY 130 SPELE RO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE week Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached in 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 X Probably 4 Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No CHRONIC OBSTRUCTIVE PULMONARY 24a. Was an autopsy performed? 1☐ Yes 2' No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To vision or 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

30, Name and address of person who com

32. Registrar's Signature 31. Date filed (Month, Day, Year)

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	th with ns 23a must b	Funeral Director	9317 Gue Road					872			ited St	ates	
92	e filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρλ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Endemoder Forces? 1 \(\begin{align*} \text{Yes} & 2 \text{If Yes}, \text{Give} \end{align*}		l l	Vas Decedent of H f Yes, specify Cuba □ Yes 2 🛣 No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - Amer Black, White	, etc.	
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Baltimore, Maryland	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (7			1	g Address (Street			. ,		Code)	
ē,	of Health of Health fitem 27 rother tra		Donald Abrams/ So 20a. Method of Disposition		20b. P	lace of Dispo	Gue Road		Date Mary		cation - City or 1	Town, State	
<u>ii</u>	Page 1 ment of tant If it iury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State fy)			natory or other place Cremator		/18/10	Fre	derick,	Maryland.	
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o	ig Physical this neral di	te: To	27. Manner of Death	/	28b. Time of 28c. Injury at 28			ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
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Division of Vital Records,			4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)					t, factory, office 28f. Location (5 City or Tov			Street and Number or Rural Route Number, wn, State)		
	Hospi 24 hour Funer eted fill	Medical	(Check 2 L Medical Exam	sician: To the best of miner: On the basis of exa	amination	and/or investi	igation, in my opinio	n, death occurred	at the time, date a	and place.	and due to the ca	ause(s) and manner stated.	
	To the within To the comple	Σ	only one) 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)							Day, Year)			
			▶ XW	(\lambda	17			20575	>+		11/161	10	
1	HIUA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Heshmat MD 4101 Old National Pike, Mt. Airy, Maryland 21771											
VC	Stat	e r	31. Date filed (Month, Day 104) 1	32. Registrar			Sarke		.				

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year Alice A. Burleson 1:30P M November 11, /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring <u>1604 Featherwood St</u> Montgomery Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 XF Director 229-26-9177 85 July 8, 1925 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 XNo Virginia Fairfax **Fairfax** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō death with "natural", or items 23a 4600 McKenzie Ave Funeral 22030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, its item Ical Examinatione. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>م</u> 1 ☐ Yes 2X No Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Insurance 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Marshall Allder Mary E. Robertson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Somers/Daughter 1604 Featherwood St, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Robertson Kidwell Cem Nov 16, 2010 Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility **Everly Funeral Home** 10565 Main St, Fairfax, VA 22030 23a. Part 1. Enter the disease, shock, or heart failure. Li omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, who one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Upper Gastrointestinal Bleed 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burlaf-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 ANo certificate Division of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 4 Other (Specify, Hospital: Daughters Home 1 Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 □Yes 2 □ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0041173 November 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Saavedra, M.D., 10301 Georgia Ave., #301, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) egistrar's Signatu State

Registrar

NOV 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#4aperMD, 11/16/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BULLARD 11.44PM FREDERICK 2010 Oct 31 /Medical 4a. Facility Name (If not institution give street and number) tal 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE Laurel GRONGE S 8. Date of Birth Now 1991 7. Age (In yrs. last birthday) 58 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 220-76-3306 Social Security Numbe 9. Birthplace (State or Foreign **Funeral** Hours Min. Days 1 💢 M 2 🗆 F Months Washington, DC Director Usual Residence of Decedent Baltimore, Maryland 21215-0036

Defruit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Beltsville Director Maryland Prince George's 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number 20705 4721 Quimby Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Edmund Bullard Betty Gough Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3943 Brittany Lane Hampstead, Maryland 21074 James E. Bullard -brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Episcopal Church Cen. 11/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Chaptico, Maryland 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** to Thrive ahure months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cate has been si page 2 should b 011500der 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗌 No 1 ☐ Yes 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. Ne Funeral Director; After the After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3411 Nov of Shesadri 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jagalish Bowie 14300 Gallant Pox # 210 CM 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature.

Registrar

NOV

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 38254 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 Day 201 Pea Physician/ NOV. 8:13 am Homer Dale Brenneman, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2205 Coffeewood Court Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Country) PA 1 🛣 M 2 🗆 F Hours 216-40-7798 68 Mar 10, Year) 9 4 2 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 X No Montgomery Silver Spring ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20906 USA 2205 Coffeewood Court ral", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or 1 🗶 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1960-64 ed other than "natu 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired.
Disaster. Recovery
Specialist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Armed Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Homer Dale Brenneman Janie L. Lackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Coffeewood Ct., Silver Spring, MD 20906 Linda Lee Brenneman/Wife other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Nov_{\bullet}^{Date} 15 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State cemetery, crematory or other place Metropolitan Crematory 2010 Alexandria, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungfal Service License Firement Asdress of Facilities Funeral Home 500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Amyotrophic Lateral Sclerosis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) cate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Asthma with COPD Records, Completed 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the function of the funct To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

of Vital Division

10+1

Medical

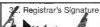
29a. Certifier

(Check

only one

State Registrar 31. Date filed (Month, Day, Year) NOV 16 2040

29b. Signature and title of certifier .



12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Trimble, MD 10810 Connecticut Avenue, Kensington, MD 20895

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D69221

29d. Date signed (Month, Day, Year) Nov. 15, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stanislaw Bilinski Not.7,2010 10:05aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2914 Burton Hill Drive Kensington Montgomery 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Min 040-26-0891 470471920 Polland 90 Yrs Director Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Md Kensington 1 ☐ Yes 2 🏲 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2714 Burton Hill Drive 20895 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo ģ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Tes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Economist Dept.of Commerce Be 18. Mother's Name (First, Middle, Maiden Surname)
Maria Lorenc 17. Father's Name (First, Middle, Last) Karola Bilinski 19a. Informant's Name/Relationship (Type, Print)
Roman Korzan/Friend-P.O.A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10112 Ashburton Lane Bethesda, Md. 2 20817 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date st.John's Cem. 11/17/2010 Forest Glen, Md 4 Donation 5 Other (Specify) 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive heart failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Failure to thrive Sequentially list for ditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ₁n and ۱-transit Atherosclerosis To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Arrythmia, atrial fibrillation, dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s autopsy performed r this certificate haral director, page 2 No 1 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After the leted filled in by the funeral 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 1 XNatural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Si

Eva

31. Date filed (Month, Day, Year,

NOA

e and title of certi

Hausner

DHMH 17 Rev 7/2009

44

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5530 Wisconsin Avenue #515 Chevy Chase, Md20815

29d. Date signed (Month, Day, Year)

Nov.11,2010

10-08766	Please Type or Print in Black Inc	delible Ink. Ensure All Copie rtment of Health and Mental H	voiene	0 000		
Cecilia Agnes Baker	State of Maryland / Depa For State Cen	tificate of Death	Reg. No.	0 38250		
R	gistrar Decedent's Name (First, Middle,Last)	amouto o. Dodo.	2 Date of Death	3. Time of Death		
Physician/ ¹ M ^{erg} ical Examiner	Cecilia Agnes Baker	Month Day Year November 15, 2010	1050 hrs			
	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Montgomery	1		
	913 Grandin Avenue	Rockville		tholace (State or		
Fulleral	Social Security Number 6. Sex 7. Age (In yrs. Ia	Months Days Hours Min	Forei	gn puntryAlabama		
	215-62-2715 1 M 2XF	57 Yrs.	Aug 11, 1933	ATADAMA		
	sual Residence of Decedent Da. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits		
Cr.		kville		1 X Yes 2 No		
trong cto	0e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?		
death with the Maryland or items 23a or 28a-f show any must be notified at once.	913 Grandin Avenue	20850		United States		
with 1 with 1 s 23s be not	Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic Origin? (S	poony . oc o	ican Indian, Black,		
r death with or items 23 must be no Funeral	Never Married 2 Married 1 Yes 2 X No		SpecifyWhit			
ral", o	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of				
hours Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)			
36 hin 72 than than	2	Housewife	Own Home			
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	7. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)			
215 be file ntal H rked ent, t	Michael F. Semancik	UNK	Dural Bouta Number City or Town Stat	e Zin Code)		
hould hould is ma attic ex	9a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or 6586 Waters Edge Court	t New Market, MD 2	1774		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient 122 or 128a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Nicholas B. Baker / Son 20a. Method of Disposition 20b. 1	Place of Disposition (Name of cemetery,	Date 21/2010 20c. Location - City of	r Town, State		
Ore, ges 1 a of He	1 Burial 2 X Cremation 3 Removal from State	crematory or other place) antic Crematory, INC	Glen Burn	ie. MD		
timent rtment rtanti y or o	4 Donation 5 Other Specify: ACL 21. Signature of Funeral Service Licensee	22. Name and Address of FacilityThi 7 Park Ave., Gaith				
Bal permi Depar Impo injur	A 1/Mue M00956					
Physician	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and		
/Medical Examiner	Immediate Cause (Final disease a. Ketoacid	osis		Death		
Examiner	or condition resulting in death) Due to (or as a consequence of	of):				
P	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):				
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of	20.				
Ex list ed (4)	events resulting in death) Last Due to (or as a consequence of					
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box 68760, the death certificate be early over the attending physicial ched for use as the bura Physician/Medi	IF FEMALE: 23c. If yes, outcome of pres	gnancy	23d. Date of delive			
587 ertifica ding p e as th	3b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of d	2 Fetal death 3 Ectopic pregr	nancy Month	Day Year		
Box 68760, e death certificate be the attending physic ed for use as the bundle hysician/Mechanical hysician/Mechanican/M	1 Yes 2 No 9 Unknown g Unknown	eath 5 Other (Specify)				
tal Records, P.O. Box 68760, ian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial-Be Completed by Physician/Medic	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to			
P.C. es that signed be determed by				obably 4 Unknown		
Records, I The law requires ficate has been sig page 2 should be Completed			autopsy prior to	autopsy findings available o completion of cause of		
eco ne law te has ige 2 s			performed? death? 1 ✓ Yes 2 No 1 ✓			
	25. Was case referred to medical	26.Place of Death (Chec				
n of Vital Reciling Physician: The After this certificate funeral director, page on: To Be Con	examiner? 1 Yes 2 No Hospital; 1 Inpatient 2		sing Home 5 Residence 6 VOtr	er: Scene		
n of ling Pl After funera	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	200. 2000 120 1101 11,000			
ivisior or Attend after death Director: d in by the	la la la la la la la la la la la la la l	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City		
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Certification: To Be Completed by P	3 Suicide 6 Could not be determined (Specify)		or Town, State)			
O E E E	4 Homicide 29a. Certifying Physician: To the best of my knowle (Check only (Check only)	edge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as si	ated.		
To the Hos within 24 h To the Fur completely Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	d at the time, date and place, and due to	the cause(s)		
	29b. Signature and title of certifier	29c. License number	29d. Date signed (M			
1-peno	N_MUL-	O.C.M.E.	November 16,			
	30. Name and address of person who completed cause of death (Ite Donna M. Vincenti, MD Assistant Medical Exa		MD 21201			
State Registrar	31. Date filed WOV 2 6 2010	A Marie				

Please Type or Print in Black Indelible Ink ը Էրդեր գ All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 12:15 AM Doris Lorraine Beal November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kent Still Pond 12541 Still Pond Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Country) Maryland (Month, Day, Year) 1/30/1955 Director 54 216-62-6397 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Still Pond MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21667 USA 12541 Still Pond Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣No Black. White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Doris Plummer William Rogers Bacon Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Still Pond Road Still Pond, Maryland 21667 12541 <u> Arthur C. Collins - Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 11/14/2010 Chetsertown, Maryland 21. Sh nature of Funeral Service Lice Fellows, Helfenbein & Newnam Funeral Home, Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between CANCER Immediate Cause (Final VARIAN Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): xaminer Sequentially list conditions, if any leading Commodiate cause. Enter Underlying Cause (Disease or linjury that initiated events ner Due to for as a nonsequence of) Exami Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 Live Birth
4 Pregnant a Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? Yes 2 X No 25. Was case referred to edical Be 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 No ပ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending 1 🔲 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurş ignature and title 29d. Date signed (Month, Day, Year) 360 Name and address of person who completed cause of death (Item 23a) (Type, Print) tim

State Registrar 32. Registr

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Amended #1,		1- For State #17, 11/22/10,	PM Kont C	extificate o	i neaith f Death	iu Meritai			00200
Physici	an/	Decedent's Name (First, Middle,Last)	Kri, Kent -	00			2. Date of Dear		3. Time of Death
Medical Exami		Seiko Cato Behr					Month November		0400 hrs
-		4a. Facility Name (if not institution, give street 110 N. Queen Street	et and number)		4b. City, Town, o	or Location of Dea	ath	4c. County of Deat Kent	h
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Ye		Irs. 8. Date of Bir		rthplace (State or
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yland yland	ctor	MD KENT 10e. Street and Number	CHI	ESTERTOW	10f. Zip Code		110	0g. Citizen of What Cou	Land of the second
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be no effect at once	Director				21620		Ţ.,	USA Japa	•
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121 Id be f Aental narked event,	o Be	Ryozo Cato 19a. Informant's Name/Relationship (Type, Pr	rint \	10h Mailin	- Address (Ct		Miyajima	ber, City or Town, State	
LD 2 shou and N 27 is n matic	2	Robert Behr - Husban	·					own, Maryl	100
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MOF Pages ent of int: If		1 Burial 2 XCremation 3 Res		crematory or of nesapeak		ion 11	/17/2010	Chester, 1	Maryland
Salti emit. epartm nports jury o		21. Signature of Funeral Service Licensee	101			s of Facility	n S Norm	onescer,	Home, P.A.
		Jason Fellows 23a. Part I. Enter the disease, or complication		1130	Speer	Road Che	stertown	. Maryland	21620
Physician /Medical		failure. List only one cause on each line		ith. Do not enter t	ne mode or dying	, such as cardiad	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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587(ertifica fing pt	ian/Med	23b. Was decedent pregnant in the past 12 months?	Live birth	2 🗌 Fe	tal death 3	Ectopic pregr	nancy	23d. Date of delivery Month	y Day Year
OX 687 ox 687 eath certific	Physici	1 Yes 2 V No 9 Unknown	Pregnant at time of Unknown	death 5 Ot	her (Specify)			A .	
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Cecc The lay sate ha	mo						perform 1 ✓ Yes 2	ned? death?	
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f Vit	မ	1 ✓ Yes 2 No	· · · · · · · · · · · · · · · · · · ·	ER/Outpatient		Other Nurs		Residence 6 Other	: Scene
on of adding Ph.	ion:	1 Natural 5 Rending	a. Date of Injury (Month, Day,Year)			Yes 2 X No	subjec	ow injury occurred t found sub	merged in
/isic	ficat	Z Accident investigation	1 11-15-10 se. Place of Injury - At			building, etc.	bathtu 28f. Location (St	treet and Number or Ru ate) 101 N. Qu	ral Route Number, City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Funeral Director: After this certificate has been signed by the attending physicial pilling in by the funeral director, page 2 should be detached for use as the burit	Certification:	4 Homicide determined (S	Specifyresiden	ce			chester	town, Md. 2	leen St. 21620
n 24 ho re Fun	cal	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the							
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Medical	2	anner stated.	and/or investigat	29c. Licens		ar me mme, date a	nd place, and due to the 29d. Date signed (Mor	1
		1 10 11 11	1)		O.C.			November 15, 20	
		30. Name and address of person who complet	ed cause of death (Ite	em 23a)					
	ŀ		stant Medical Ex	aminer 11	1 Penn Stree	t, Baltimore,	MD 21201		
		31. Date filed (Month, Day, Year) 6 2010	32. Redistrar's Signa	ature .	Was J				
Regist	raï	MOA T 79 COLO	JUNE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1325 VOV 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERON KENT ESTERTOWN Year If Under 24 Hrs.

Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 28 9171 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show KENT MD 1 XYes 2 □ No Funeral Director CHESTERTONN 10e. Street and Number 10g. Citizen of What Country? EAST CAMAIS AUENUE Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AROLD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LANE HARULD permit. Pages 1 and Department of Healt Important: if item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZUT CREEN HERON WAY CHES 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in in ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADVANCED 2 No 3 Probably 4 Unknown Completed 24a. Was an Was an autopsy performed?
Ves 250 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) I Director; After the in by the funera 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041587 when un 30. Name and address of person who completed cause of death (Item 23a) Type, Print Chasterrown Md 21620

State Registrar

31. Date filed (Month, Day, Year) NOV 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#9 11/12/10, TM, Kent Co 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 34rRe 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner en ler7 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 M 2 DE 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanting must be notified at 1 Yes 2 No Director KENT CHESTERTOWN Mo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CALVERT U.S.A. STREET 21620 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates þ Specify. Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Usual Occupation.
(Give kind of work done during most of working life. DO NOT use retired)

HOUSE KEEPER Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NANNY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY JOHNSON COMEGY NEAD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HADAWAY DR CHESTERTOWN, MO KONALD APT 6A STER 200 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 128 Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 11/13/2010 CHESTERTOWN MD 22. Name and Address of Pacility BEWNIES MITH FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 855 HIGH STREET CHESTERTOWN MO 21620 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician nunutes Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/3/3 1/1/1/1lun In 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KINK. WUN, 415 Washington Ave, Chestertown, MD 21620 31. Date filed (Month, Day Year) 1 2 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Helen Watts Bell November 1:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chestertown Chester River Manor Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours (Month, Day, Yes 04/16/191 Country) Pennsylvania **Director** 173-05-1832 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🖁 No Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21620 326 River Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 🕅 Widowed 4 🗆 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education English Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Estelle J. Elmer Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Harrington Be</u>ll - Son PA 19083 1318 Annabella Ave. Havertown, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) 11/08/2010 Chester, Maryland Chesapeake Cremation Signature of Funeral Service Name and Address of Facility 11lows, Helfenbein & Newnam Funeral 30 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 140 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c, License number 29d. Date signed (Month, Day, Year) 021313

Rm

State Registrar Chestertown MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 510WM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Millington Ween 5. Social Security Number If Under 1 Year J Under 24 Hrs 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Min. Hours **Director** Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Millington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21651 River Road 18A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? þ Black, White, etc. ö 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tould be filed within 72 and Mental Hygiene. Elementary/Şeconday (0-12) College (1-4 or 5+) Employed Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stevens CAVE and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau Road Millington, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chester MD e Crematon 10/2010 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Fe 10 WS HE FC Newnam Funeral Home Road nester town, MD 21620 23a. Pat 1. Enter the disease, or complication what caused the nest is k, or heart failure. List only one course on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Draestive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I this certificate 2 10 1 Yes **Division of Vital** director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After thi funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 No 2 Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11/12/10, Kent Co. TM Amended #5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 6, 2010 Physician/ 5:15 A M Sara Pepper Beasley Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Centreville Hospice of Oueen Anne's 9. Birthplace (State or Foreign Country)
DE 5. Social Security Number 222 - 03 - 7792 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days 1 🗆 M 2 💢 F Hours Director 90 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Chestertown MD Kent 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21620 USA 329 Calvert Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Factory Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edith Shockley <u>Greensbury Pepper</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 613 Chestertown, MD 21620 Kenneth Beasley-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Chesapeake Cremation 11-8-2010 4 ☐ Donation 5 ☐ Other (Specify) Chester, MD Signature of Funeral Service Licenses 22 Name and Address of Facility Fellows, Helferibein & Newnam Funeral Home mas 11 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sour mous Cardinom 3 Pnysician Endocorvica disease or condition resulting in death) 3 years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death signed by the attendir 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) D0050996 8 2010

Registrar

31. Date filed (Month, Day,

CC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BARA 0020 M 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Tate House Linthicum Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🙀 Months Days Hours Min (Month Day, 72 1938 Illinois 340-32-8053 May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Bowie 1X Yes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA 15704 Pinecroft Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Pre-School Pre-School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Janet Bertram Richard W. Strauss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD Richard H. Boell / Spouse 15704 Pinecroft Lane, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/13/2010 Davidsonville, MD Lakemont Mem. Gards. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death 4 ROS resulting in death) Due to (or as a consequence of) Sequentially list conditions, Dise to for as a nonsequence off cause. Enter Underlying

Physician/ Medical Examiner

injury o

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

28a-f show

items 23a or

ō

"natural",

Page 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '

Baltimore, Maryland 21215-0036

or other traumatic event, the Medical Examiner must be notified at

Completed by Funeral Director

Be

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Examiner Physician/Medical Completed by Be

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Certificate:

Medical

signed by the attending physician and d be detached for use as the burial-transit After this certificate has completed filled in by the funeral director, page 2 after death Director: /

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

29b. Signature and title of certifier

2 No

5 Pending

Investigation

6 Could not be

NOV 1 5 201

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident
3 Suicide
4 Homicide

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

28a. Date of injury (Month, Day, Year)

Pregnant at time of death

Due to (or as a consequence of):

9 Unknown

1 Inpatient 2 I ER/Outpatient 3 DOA

28b. Time of

iniury

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐷 Unknown 24a. Was an

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

Year

performed? Yes 2 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Dother} \) Other (Specify) 28c. Injury at 28d. Describe how injury occurred

2 No 1 Yes

	_ Suicide □ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Certifier 1 Check 2	Certifying Physici	ant: To the best of my knowledge, death occured at the time, date and place, : On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner
C	only one) 3	B Certifying Nurse F	Practioner: To the best of my knowledge, death occurred at the time, date and p	ace, and due to the cause(s) and manner as stated.

9b. Signature and title of certifier	1/0 5	4. \	
Signature and title of certifier the signature and title of certifier.	Kreigh	nis	

29c. License number

work? 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EGER

State Registrar

DHMH 17 Rev 7/2009

e Funeral I

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claude Michal Buchanan November 12, 2010 6:45 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Frederick 4b. City. Town, or Location of Death **Examiner** 6133 Mountaindale Road Thurmont . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Sept. 19, 1944 North Carolina 216-42-9900 66 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Frederick Thurmont Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **United States** 21788 6133 Mountaindale Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner , or ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White Specify: "natural" Completed 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Construction Welding Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Buchanan Marie Edge **Claude** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Michaelson** Buchanan / Son 202 Strawberry St./ Richmond, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State

Stauffer Crematory

22. Name and Address of Facility

Nov.17,2010 Frederick, Maryland

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

Physician/ Medical **Examiner**

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

Baltimore, Maryland 21215-0036

Examiner Medical Certificate: To Be Completed by Physician/Medical been signed by the should be detached page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director,

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final	ns that caused the death. Do not enter the mode of dying, such as se on each line.	cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death				
disease or condition	CIPPADSIN of /IV	21		Trosy				
	Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury								
that initiated events resulting in death) Last C. Due to (or as a consequence of):								
d								
in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Unknown		23d. Date of de Month	livery Day Year				
Part II. Other significant conditions contributi	ing to death but not resulting in the underlying cause given in Part	I. 23e. Did to	obacco use contribute to	the cause of death?				
		1 🗆	Yes 2 No 3 P	robably 4 🗌 Unknown				
		24a. Was	an 24b. Were au	topsy findings available				
		autop perfo 1 🗆 Yes	rmed? death?	completion of cause of				
25. Was case referred to medical examiner?		ath (Check only one)						
1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N	ursing Home 5 Resid	dence 6 Other (Spec	cify)				
1 Natural 5 Pending 2 Accident Investigation	ia. Date of injury 28b. Time of work? (Month, Day, Year) 28b. Time of work? M 1 \(\sum \) Yes 2	28d. Describe I	now injury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,				
(Check 2 Medical Examiner: On	To the best of my knowledge, death occured at the time, date and the basis of examination and/or investigation, in my opinion, death o tioner: To the best of my knowledge, death occurred at the time, dat	ocurred at the time, date a	and place, and due to the	cause(s) and manner stated.				
29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont					
1 Seulh	Vemble md 31058 11/15/10							
30. Name and address of person who complete								
	00 Coppermine Rd./ Woodsboro,	Maryland 2	21798					
31. Date filed (Month, Day, Year) NOV 1 7 20	32. Registar's Signature D. Janes							

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOV -2010 Year EDWARD BREWER BYRD 16 10:45A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16301 SUGARLAND ROAD BOYDS MONTGOMERY . Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Months Days Hours Min 10/06/ **Director** WASH. 218-16-0623 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits, MONTGOMERY 1 ☐ Yes 2 ☑ No MD BOYDS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20841 16301 SUGARLAND ROAD items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner I 14. Race - American Indian, Armed Forces?/
1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2 ☑ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) AGRICULTURE FARMER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH D. BYRD LILLIAN BREWER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRMA MARIA J. BYRD/SPOUSE SUGARLAND ROAD, BOYDS MD 16301 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BYRD FAMILY FARM 11/20/2010 4 Donation 5 Other (Specify) BOYDS, MD 21. Signature of Funeral , ervice Licens 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ATRIAL FIBRILLATION Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year n signed by the a Id be detached fo g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed DIABETES (TYPE II) 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should been ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy HYPERCHOLESTEROLEMIA performed? Yes 2 No After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1. Natural injury 5 Pending Accident Suicide Investigation 1 Tes 2 🗌 No Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. hin 24 hours aft the Funeral Di npleted filled ir Medica 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) H61505 11/17/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pooles ville Duggirula 0.0. 19710 SKJ MD /mar F.sher 10 31. Date filed (Month, Date ,32. Registrar's Signature State Registrar **ORIGINAL**

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 842 ennu VOU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 121 Brewster Bridge Road Elkton Cecil Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 X M 2 D F Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country Month, Day, Year) Months Days Hours Min. 217-48-4080 50 **Director** Aug. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Elkton 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 121 Brewster Bridge Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry
Fastrak, Express
Trucking (Specify only highest grade completed) Elementary/Seconday (0-12)
Ten Years life. DO NOT use retired) College (1-4 or 5+) Truck Driver Rising Sun, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Albert Lee Barton Peggy Jean Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly L. Shifflett Barton (wife) 121 Brewster Bridge Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, R.A.Ferris & Co., Inc. 11/19/10 Pennsylvania ture of Funeral Service Lice e A. Patterson & Son Funeral Perryville, Maryland 21 21. Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) na **Medical** Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence off. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year ☐ Yes 2 ☐ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?
1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar (Month, Day, Year)

NOV 22 2010

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Franklin Theodore Beckman 2010 10:45 a^M 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital Garrett 0akland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days (Month, Day, Year) Months Hours Min 214-28-7150 Director 05 Ĩ931 Sines MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Garrett 0akland 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 18848 Garrett Highway 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene.
I other than " Elementary/Seconday (0-12) College (1-4 or 5+) contractor construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H
27 is marked of
traumatic eve ည Lemmie Beckman Edna Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2.
Department of Health a
Important if item 27 is,
any injury or other Betty Mae Beckman-wife 18848 Garrett Highway, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Pleasant VAlley Cem | 11/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21. Signature 21 N. 2nd St, Oakland, MD 21550 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Melisnant hx Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (of as a consequence of) use as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of history Records, 1 Yes 2 No 3 Probably 4 Unknown caratid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes or Attending Physician; 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 은 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death.

neral Director: After tilled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital of within 24 hours at To the Funeral D Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/24/2016 D 0063335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eglan Clinic, Pu Box 8, Eglan, WV 26716 Foy 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			Please Type or P					•	
			1 - State of State of Registrar	Maryland / Depa	artment of He rtificate of De		ental Hygiene Reg. No	2010	38269
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Paul Eden Brashear			2	. Date of Death November Da	23 2010	3. Time of Death 6:21 PM M
	Examir		4a. Facility Name (If not institution, give street and number 24537 Stoney Run Road	per)	4b. City, Town, or Lo Westernp	ocation of Death	40	. County of Death Allegany	
	Funeral Director		5. Social Security Number 218-30-0407 6. Sex 1 24 M 2 □ F	Age (In yrs. last birthday) 76 Yrs.		f Under 24 Hrs. 8 Hours Min.	Date of Birth March Day Year March 30	9. Birth Cou Mai	place (State or Foreign ntry) and
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State MD 10b. County Allegany	10c. City, Town or Lc Western					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	th with the 23a or 28i	al Direc	10e. Street and Number 24537 Stoney Run Road			tizen of What Cou ited Stat			
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Deced Armed Forc 1 ☑ Yes 2 If Yes, Give Year or Date	□ Korean	Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2 ☑ No	anic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.	ompletec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) erator	on ing most of working		aind of Business/Ir	. ,
Maryland		To Be (17. Father's Name (First, Middle, Last) William Brashear		18	B. Mother's Name (First, Middle, Maider Miller	n Surname)	
, Mar		ľ	19a. Informant's Name/Relationship (Type. Print) Barbara Brashear/ wife		ng Address (Street and 7 Stoney Ru				
Baltimore,	Pages 1 ament of He tant: If item jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	Cumberlar	Disposition (Name of y, crematory or other place) Tland Crematory 11/24/2010 Cumberland Maryland				
Ball	permit Depar Import any in		21. Signature of Funeral Service Licensee	/7	2. Name and Address of 11 Church S				21562
	Physician /Medical Examiner			,	ter the mode of dying,			itastasis	Approximate Interval Between Onset and Death
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):					-
68760,	ate be exer nysician ar he burial-tr	_	resulting in death) Last Due to (or	as a consequence of):					
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be delached for use as the burial-transit	Physician/Medica	in the past 12 months?	nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ery Day Year
Records, P.	or Attending Physician: The law requires that the de lifter death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director, page 2.	þ	Part II. Other significant conditions contributing to dea		nderlying cause given i		23e. Did tobacco 1 ☐ Yes 2		the cause of death?
al Reco	: The law r cate has be page 2 sh	Completed					24a. Was an autopsy performed? 1 □ Yes 2 □ No	prior to co death?	opsy findings available ompletion of cause of 2 \square No
Vital	clan ertifi ector	Be	25. Was case referred to medical examiner?			6. Place of Death (Check only one)		
of\	hysi this c		1 Yes 2 No Hospital: 1 □ Inp	oatient 2 ER/Outpatier			35 Residence		fy)
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Divis	il or Attendi after death, Director: A d in by the fu	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, farm, str , etc. (Specify)	reet, factory, office	28	f. Location (Street a City or Town, State	nd Number or Run e)	al Route Number,

Medical Certification: To Be

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To the Hospital or Attending Physiclar within 24 hours after death.

To the Funeral Director: After this certif completely filled in by the funeral director

		autopsy prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other	4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) Certifying F 2 Medical Example	nysician: To the best of my knowledge, death occurred at the time niner: On the basis of examination and/or investigation, in my opi and manner stated.	e, date and place, and due to the cause(s) and manner as stated. nion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 921244 29d. Date signed (Month, Day, Year) 11/24/20110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532

State Registrar

4

31. Date filed (Month, Day, Year) NOV 2 9 2010



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** \mathbf{A}^{M} ISABEL LARRICK BROWN 10 30 2010 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CANDLE LIGHT COVE **EASTON** TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 K F Days Hours 230-24-2129 85 Director 06/21/1925 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it a Medical Exolair ar mast be reathed at Director 1 ☐ Yes 2 ▼ No MD TALBOT EASTON 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 29361 WOODRIDGE DRIVE 21601 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: WHITE 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) HEALTH CARE OFFICE MANAGER permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event. III 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be EMORY NELSON LARRICK MABEL VIRGINIA PATTERSON ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. BLAIR BLIZZARD / DAUGHTER 29495 NANCY STREET, EASTON, MD 21601 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION
CENTER 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/4/2010 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD ona Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ewer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dise to (or as a consectiving) of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Exami burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **10**0 Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BOKKIN, CANP 32. Registrar's Signature

Print) 8579 Commerce Da H 106, ETETEN, M.D. 21601

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 29 PATRICIA A. BENJAMIN 2010 10:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT 8. Date of Birth (Month, Day, Year) 09/02/1925 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1 □ M 2 🗶 F Days 213-70-7730 85 Director IL. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercition and be notified as Director 1X Yes 2 □ No MD TALBOT **EASTON** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 29388 GOLTON DRIVE 21601 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 □ Yes 2 🗶 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 is marked otl WALTER ARNOLD MARJORIE (UNKNOWN) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY S. CLARKE, PA 283 MILL ROAD COOPERSTOWN, NY permit. Pages 1 and 3 Department of Health Important; If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11/3/2010 CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 SOUTH HARRISON ST., EASTON, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Culs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 2 No 1 □ Yes 2 or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' 2 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 X \square$ Other (Specify) HOSPICE After this c funeral din 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐Yes 2 ☐ No hours after death I Director; of in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number

State Registrar

DAVID H. SMITH 31. Date filed (Month, Day, Yea NOV 03 2010

29b. Signature and title

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221 TEAL DRIVE, STE. 301, EASTON, MD

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D39887

29d. Date signed (Month, Day, Year)

2010

Physician /Medical Examiner

1 - For State Registrar

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MD

Physician /Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once.

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and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

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as the burial-trai physician attending p detached the signed by þ need page 2 has certificate within 24 hours after death

To the Funeral Director: A
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Records, P.O. Box 68760

Division of Vital

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edical Examiner	Sequentially list conditions, if any, reading or immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	· · · · · · · · · · · · · · · · · · ·					
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Completed					24a. Was an autopsy performed?	prior to death		ngs available of cause of
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
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ation:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred		
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dical		ysician: To the best of my kno niner: On the basis of examina and manner stated.						ise(s)

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600 North Wolfe St, Baltimore, MD, 21287

Vem Der 12, 2010

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State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

NOV

Darke

and address of person who completed cause of death (Item 23a) (Type, Print)

9 2010

32/Registrar's Signature

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Alfred Ballard	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 | 0 38273 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar				Certific	ate of	Death				Reg. No	o .		
N edic	Physic al Exam		an/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time							3. Time of Death 1707 hrs						
andere .		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 30550 William Hytche Blvd Princess Anne						-		c. County o						
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birt	hday)	If Under 1 \	ear If U	Under 24Hrs.	8. Date of	Birth (MI	WDD/YYYY	9. Birt	hplace (State or Foreign
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	any		10a. State 10b. Coul	ity		10c.	City, Town	or Locatio	n							10d. Inside City Limits
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7	Maryland 28a-f show 1 at once.	Director	10e. Street and Number			l			10f. Zip Cod	9	-		10g. C	itizen of Wh	at Cour	itry?
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21	d Mer s mar tic ev	70	19a. Informant's Name/Relation	onship (Type,	Print)		198	. Mailing	Address (St						, State,	Zip Code)
MD	and 2 should be filed within 72 hours after death with the Maryland feeth hand Mental Hygiens free from them 25 or 28a-f she ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Ms. ir. A Ex. miner must be notified at once traumatic event, the Ms. ir. A Ex. miner must be notified at once		Priscilla D	rummo	nd/Mo											, MD 21853
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Baltimore,	permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Mediury or other traumatic event, the Mediury or other traumatic event, the Medium Real Real Real Real Real Real Real Real		21. Signature of Funeral Serv	ce Licer see	171			22. Na Be	me and Addr nnie neral	ess of Fa	cility 91	7 W.	Isa	bella	a S	t.
	•		23a. Part Lanter the disease	or complication		ugod tho c	loath Da no	Fu	neral	Hon	ne Sa	lisbu	ry,	MD A	218	
	ıysician Medical		failure. List only one cau	se on each lir	ie.								arrest, si	lock, or flea		Approximate Interval Between Onset and Death
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		miner	if any, leading to immediate cause. Enter Underlying Cau		o (or as a	consequer	nce of):									
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89	eath certific e attending p for use as th	siciar	past 12 months?	4		nt at time			I death :	ECT	opic pregnar	icy	10	Month	D	ay Year
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one) 1 Certifying one) 2 Medical E	caminer: On the		examinati										
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			Zabiullah Ali, M.D.	Assistant	6				Street, Ba	Itimore	e, MD 212	01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19acb Per FH G910 12/07/10 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical City, Town, or Location of Death Name (if not institution, give street and number) Examiner 4c. Co MODIN 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Day, 1 🗆 M 2 🗶 F Months Days Hours Min. Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a 10b. 10c. City, Town or Location 10d. Inside City Limits Director MEN 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Re ant 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐ Never Married 2 ☐ Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) aw Be 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) mmons ပ DINNIC 1670 509 Et Mais (Free end Symbol of Bural Route Number, City or Town, State, Zip Code) 20747 Stephanie Smith Paughter Distruct Hiegh IMD acygn Q ANUNIO SMILLA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place verdole Signature Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Domentin disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebral VASCUIN Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed , page 2 should be del 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🕦 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 🔲 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending n 24 hours after death.

e Funeral Director: A pleted filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 7 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

32. Registrar Signature

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11701 Guingston Rond

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAWAGE MY

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NOV 2 3 2010

31. Date filed (Month, Day, Year)

7.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ethel 5:30 M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner BENNETT NURSING HOME GARRETT OAKLAND 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 □ M 2 🛱 F Director FREEPORT, 206-12-7967 86 14,1924 AUG. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1√∑Yes 2 ☐ No MD GARRETT MT. LAKE PARK filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 509 E STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, Irai once. 12 OFFICE CLERK DEPT. STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ RACHEL M LONG WALLEY FRGA M. WALLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 EAST STREET, MT. LAKE PARK, MARYLAND 21550 RUSSEL BOWSER (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) WVU MEMORIAL VAULT 11/30/10 MORGANTOWN, WV 22. Name and Address of Facility WVU HUMAN GIFT REGISTRY 21. Signature of Funeral Service Licensee Roleit PO BOX 9131, MORGANTOWN, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cerebral vascu accid **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) the detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐Yes 2**X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 To the I e and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oubland, Md 21550 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death
Month Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9,2010 3 05 PM beth Za /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT 7. Age Vin yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

M
D Social Security Number **Funeral** Days Months 1 ☐ M 2 🕱 🥫 317-12-420 Usual Residence of Decedent 89 Director filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐Yes 2 No Completed by Funeral Director QUEEN ANNES MID HESTERTOWN 10e. Street and Number 10g. Citizen of What Country? 115 EWINGTOWN RD USA 21620 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE FAMILIES HOUSEKEEPER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be GREEN ANDERSON 19a. Informant's Name/Relationship (Type. Print) GRAMON 19b. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 620 10790 FERMOYRD item 27 l 20c. Location - City or Town, State SHARONE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State RICH NECK CEMETERY 11-16-2014 CHESTERTOWN MD

122. Name and Address of Facility 855 HIGH ST. CHESTERS OF MYMO 4 Donation 5 Other (Specify) 21. Signature of Pineral Service License BENNIESMITH FUNERAL HOME 23a. Par I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) fulmonin Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the draying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 11 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannal of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

KINK, WUN, M.D.

KINK. WUN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

415

Washington Ave, Chestertown; m)

D2/313

11/11/10

21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 20^YPO 3:55 Ellen Ross Coleman Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown Kent 8. Date of Birth (Month, Day, Year) 11–19–1922 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Country) 87 MD Director 219-36-7422 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No MD Kent Chestertown 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 26761 Mallard Rd. 21620 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ John Price Johnson Marim Duling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Coleman/brother-in-law Stone Tower Lane Wilmington, DE 19803 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or Sudlersville Cemetery 11-10-2010 Sudlersville, MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the des shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final autoa Ph sician/ recores bears disease or condition Medical resulting in death) Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ner Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Day Month Year s been signed by the sahould be detached 9 Unknown 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 s autopsy death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, Mos 8/10 m, D 0017036 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m D. 31. Date filed (Month, Day, Year) 32. Regist State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 10, 2010 7:10 A M John Dickens Clithero 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Catonsville Renaissance Gardens at Charlestown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 84 574-05-6848 Washington 15, 1926 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 No Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 709 Maiden Choice Lane, Apt# S326 12. Was Decedent Ever in U.S. Armed Forces? 101 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1944-1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1961 1 ∐Yes 2 📉 No Specify. White Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Meteorology Meteorologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Clithero Gordon Dickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 80 Beechwood Drive Lewisville, NC 27023 John Clithero / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 11 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervice Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each light. 23a. Part 1. Enter the disease shock, or heart failure. with inamelar Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Samue study list over the ne 23d. Date of delivery use contribute to the cause of death? ☐ No 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

1∩a State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Perfect Experient and the Lording of

Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.

of Health

item 27

= 6 Department o Important: If any injury or once.

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

physician and the burial-trans been signed by the should be detached

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Be Completed by

Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier

(Check only

29b. Signature and title of certifier

within 2 State Registrar

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	Ideath 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not rea	ulting in the underlying	eause given in Part I.		ouse contribute to the cause of death
				24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 Yes 2 Abo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street City or Town, Sta	reet and Number or Rural Route Number, n, State)		

and manner stated

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, NOV 1 5 2010 32. Redistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month arriet 9:40 PM 2010 Novembe: Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Severna Park Heartlands Assisted Living If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs (Month, Day, Y April 12 1 □ M 2 🔯 F Months Hours Pennsylvania 217-22-0168 96 .1914 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director Severna Park Anne Arundel 1 Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21146 USA 444 Lakeland Road N Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administration Office Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Sarah Phillips Emmor Marsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 444 Lakeland Road N Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Sarah Outten / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Pennington in Pe 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Dother (Specify) Department or Important: If any injury or Atglen, PA Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a, Part 1 Energhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
ULarS Immediate Cause (Final Ph_sician/ disease or condition resulting in death) conae Medical Examiner a consequence of Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ģ in the past 12 month 1 Yes 2 10 Month Year Day Pregnant at time of death 9 | Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1881+00 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Sp this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **L** atural iniury 5 Pending 1 ☐ Yes 2 ☐ No after death. Accident Investigation the t 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a, Certifier 🚺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of ce ne and address of person who completed clause of death (Item 23a) (Type, Print) ar's Signature

State

Registrar

NOV 1 5 2010

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3067-A Riverview Road Riva 5. Social Security 5022 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/23/1927 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs 83 Director 578-34-5402 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State traumatic event, the Medical Examiner must be notified at Directo Anne Arundel Riva Maryland| 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21140 United States 3067-A Riverview Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington, D.C. Elementary/Secondary (0-12) College (1-4or 5+) Recreation Director Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalino Cocimano Mary Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Suzanne R. Cocimano/Wife 3067-A Riverview Road, Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 11/17/2010 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signature of uneral Service Licenses 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 146 /Medical Due to (or as a consequence of) Examiner Orto Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Physician

/Medical

Physician/Medical

<u>م</u>

Completed

Be

Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit man.

Division of Vital Records, P.O. Box 68760,

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown
Part II. Other significant conditio	ns contributing to death but not

1. Decedent's Name (First, Middle, Last)

Philip Randolph Cocimano

4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)
contributing to death but not resulting in	n the underlying cause given in Part I.

etal death

underlying cause given in Part I.	23e. Did tobacc	o us	se con	tribute to the cau	use of death?
	1 □ Yes	2] No	3 ☐ Probably	4 🗌 Unknown
	24a. Was an autopsy performed		24b.	Were autopsy fi prior to completi death?	on of cause of

Su.te 216

2. Date of Death

November

					TLIYES ZEINO	1 162 2 100			
25. Was case referred to medical		26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ⊡	No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 🗍 I	Home 5 Residence 6 □Other (Specify)					
27. Manner of Deat 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the second control of	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,			
29a. Certifier (Check only one)		nysician: To the best of my kno niner: On the basis of examina and manner stated.							

3 Ectopic pregnancy

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 5 per FH G910 12/9/10 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

29b. Signature ar	a title of certifier
	2 2/10
	N YV
20 Name and as	Intrace de la company

29c. License number									
065272									

29d. Date signed (Month, Day, Year)

38280

3. Time of Death

Рм

11:12

9. Birthplace (State or Foreign

Washington, D.C.

White

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

2010

Anne Arundel

14. Race - American Indian,

Black, White, etc.

Specify:

4c. County of Death

11/12/2010

23d. Date of delivery

Month

completed cause of death (Item 23a) (Type, Prip 2003 70812.1

001201	1.100
31. Date filed (Month, Day,	Year)
NU/	15 2010
1101	TOFOID

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 0245 Semar Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 2519 Painter Court 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 1 □ M 2 😿 F 85 7M25 97925 PA 205-14-2381 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Annapolis Anne Arundel Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? USA 10e. Street and Number 21401 2519 Painter Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married ò Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates Completed 3 → Widowed 4 □ Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorothea Miltz မ James Convery 19a. Informant's Name/Relationship (Type, Print)
Rosemary Elger - Daughter 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 545 Epping Forest Rd, Annapolis, MD 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Vet. Cemetery 1 X Burial 2 Cremation 3 Removal from State MD 11/17/2010 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 205 disease or condition Medical resulting in death) or as a consequence of Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year a 🗍 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 **P**Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier

State Registrar 30. Name and address of person who completed cause of death (1em 23a) (Type, Prin

5 201

NOV 1

31. Date filed (Month, Day, Year)

Box 68760 P.0. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; Division of Vital

> State Registrar

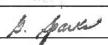
Medical

29a. Certifier

F120 25 11 Auc 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITTO ...



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MO51610

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amended #25 pe	State of M	laryland G FCH	d / Depa Cent	rtment of	Health Death	n and M	1ental Hy	giene Reg. No.	010	382	283
			1. Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time o		
	Physicia Medic		Mary Christina Carretta November 11, 201									2:53	A. M	
	Examin		4a. Facility Name (if not institution, give street House	et and number)			4b. City, Towr Rockvi		n of Death			inty of Deat ntgom		_
	Funeral Director		5. Social Security Number 6. Sex 1	7. A	ge (In yrs. la	st birthday) Yrs.		f Under 1 Year If Under 24 Hrs. 8. Date of onths Days Hours Min. (Month			irth 9. Birthplace (State of Country) 9, 1965 Virginia			or Foreign
		ŀ	Usual Residence of Decedent											
	yland f sho	tor	10a. State 10b. County		·	, Town or Loc					in-		10d. Inside C	s 2 No
	e Mar r 28a- notifi	<u>Siré</u>	Maryland Montgome 10e. Street and Number	ry	Ge	rmanto	√n 10f. Zip Cod	e			10g. Citizen	of What Co		X
	vith th 23a o st be	eral	19515 Frederick Ro	ad				208	376		US		,	
	eath v	Funeral Director		2. Was Decedent Armed Forces		. 13. W	as Decedent o	f Hispanic	Origin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	rican_Indian,	
30	after d ", or i	2	1 X Never Married 2 Married	1 ☐ Yes 2X If Yes, Give			Yes 2X					Specify: white		
Ş	ours a atural cal Ex	Completed	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates.		16a. Deced	ent's Usual Oc	cupation			16b. Kind	of Business	Industry	
212	n 72 h an "n Medi	dm	(Specify only highest grade Elementary/Seconday (0-12) 12	completed) College (1-4 or	r 5+)	life. DC	ind of work do NOT use retir	ne during m ed)	ost of work	ing				
21	if filed within 72 hours after death with the Maryland Hydene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Co			<u> </u>	Cas	hier	T				omotiv	re	
and	be filed within 72 hours after death with the Maryland kentel Hyglene death-Hyglene "natural", or items 23a or 28a-f sho to event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Anthony Carretta							e (First, Middle Schoet				
چ	2 should be filk Ith and Mental I 27 is marked c r traumatic eve		19a. Informant's Name/Relationship (Type	, Print)		19b. Mailin	g Address (Str	eet and Nur	nber or Rura	al Route Numb	er, City or Tow	n, State, Zi	p Code)	
Ĕ	d 2 sh alth a n 27 is er trau		Flavia Carretta -	mother						ce, Fre				21701
ore	e 1 and of Heal if item or other		20a. Method of Disposition 1 Burial 2XXCremation 3 Re	emoval from Sta		emetery crem	sition (Name of atory or other	olace)	i	Date 2-2010	1		Town, State	nd
Baltimore, Maryland 21215-0036	t. Pag rtment rtant: njury e		4 Donation 5 Other (Specify)		Sta		Cremato		:					iiu -
Ba	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service Licensee	nelle	. Col					auffer ke, Fre				21702
		4	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caus cause on each li	ed the deatl	n. Do not ente	r the mode of	dying, such	as cardiac	or respiratory a	rrest,		Approxima Interval Be	etween
ı	nysician/		Immediate Cause (Final disease or condition	Malign	ant n	eoplas	m of ph	arynx	2			(0)	Onset and months	
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		Jer	Sequentially list conditions, b. if any, leading to immediate	Due to (or a	s a consequ	uence of):								3
	uted d ansit	Examiner	Cause. Linter Underlying Cause (Disease or linjury that initiated events c.									* •		
	exection and and and and and and and and and an	EX	resulting in death) Last	Due to (or a	is a consequ	ience of):								
9	ath certificate be executed attending physician and for use as the burial-transit	edical	d.											
1 89	pertific nding l	n/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcom	ne of pregna	ncy	Letonio aros				230	. Date of de	elivery	1
30X	death on attended for the	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	t at time of o		Other (specif					Month	Day	Year
0	requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions cont			ulting in the u	nderlying caus	e given in P	art I.	23e. Did	tobacco use	contribute t	o the cause of	death?
ა, თ.	signed d be d	d by	Alcohol withdray							1 🗆	Yes 2 🗆	√o 3 🗆 F	robably X X	Unknown
ord	requi	olete	Alcoholism 24a. Was an autonsy prior to completion of cause of prior to completion of prior to completion of cause of prior to cause of pri											
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Ž	Physic this o	은	1 XYes 2 No.	1 Inpa		ER/Outpatier 28b. Time of	t 3 L DOA	Other: 4 🗆	Nursing H	ome 5 Res			_{cify)} Hosp	ice
O COUNTY OF THE POLY OF THE PO								now injury occurred						
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								Pause(s) and n	nanner as s	tated				
								a due to the	cause(s) and n	nanner stated.				
	To the To the To the Comp	only one) 3 — Certifying Nurse Practioner: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and mainler as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
			1 Gen					37142	2		11-	11-20	10	
			30. Name and address of person who cor G. Coleman 1.	mpleted cause o	f death (Iten	n 23a) (Type, F Prive.	Print) Suite	100. 1	Rockvi	ille, M	arylan	d		
	5 Sta	te.	31. Date filed (Month, Day, Year)								y =			
	Registr		NOV 18	2010 DX	Leaven	J. 12.	La Carrie							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death Reg. No Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 09:37PM Walter, Dake, Cooper 2010 NOV. 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical
5. Social Security Number center Baltimore 7. Age (In yrs. last birthday) Funeral If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months 1 X M 2 □ F Min. Hours MARCH 2, Year) 1955 55 Director 235-90-3145 MARYLAND Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code ö items 23a or ner must be n 10g. Citizen of What Country? Funeral 402 WINTON AVENUE 21601 IISA death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White etc 5 þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) CADMUS College (1-4 or 5+) 12 0 PRESSMAN IOURNAL SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CATHLEEN SAUCER JAMES A. COOPER, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN C. COOPER, WIFE 402 WINTON AVENUE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State ST. JOSEPH'S CEMETERY 11/8/2010 CORDOVA, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 SOUTH HARRISON STREET, EASTON, MD HOME, I 23a. Part 1. Enter the disease, or complication t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ Tracheoesophageal vear Medical Examiner sophoed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (as a co equence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate Yes 2 X No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\sum \) No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month. Dav. Year)

State Registrar

Danie M.D. 31. Date filed (Month, Day, Year) **Pegistrar's Signature**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street, Baltimore, MD

Nov-,01,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 0829 Claude Charles Vember Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Vicomic alisbur Poninsula Regional Medical Center If Under 1 Year If Under 24 Hrs 8. Date of Birth Month, Day, Year) Mar 28, 1940 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 1 3 M 2 - F Months 126-50-5328 70 Haiti Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director Salisubry 1X Yes 2 No MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21804 USA 912 Lochraven Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc.
African-1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Line Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Limina Alfreus Ledy Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 912 Lochraven Road, Salisbury, MD 21801 Evens Datilus/stepson 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Green Acres
Memorial Park 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 11/20/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Road, Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, Examiner Directo for an elegence off if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be examiner? 2 No ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 29b. Signature and title of certifier ho completed cause of death (Item 23a) (Type, Print) 191 910 Registrar's Signature State Registrar

38286 State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 Mary Ireland Calloway 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homestead Manor Denton Caroline 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign Country) Mary 1 and **Funeral** Days Hours 1 □ M 2 🎖 F Ju^{(Month}, 1²⁵, ^{Ye} 1926 84 Maryland **Director** 218-20-8636 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🏋 Yes 2 □ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Colonial Drive 21629 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Ireland Annie Greenlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meyers/ daughter 507 Academy Street; Greensboro, Maryland 21639 Janet 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Nov 23 2010 Hillsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 21. Signature of Funeral Service License $^{22.\,\text{Name and Address of Facility}}PO$ Box 160, Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) advanced ementi Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed' this certificate Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? I Director: After to in by the funeral Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D002 3922 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) But Ave Perston Lednum MD Welsuga 136 31. Date filed (Month, Day, Year) NOV 3 2 2010 32. Registrar's Sanature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 3:05p м NOV. 9, 2010 Hilda J. DeMatteo **Physician** /Medical 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** 1/07/044/1920 PAuntry) 1□M 2 F Days Hours Months 059-16-4113 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be rectified at Silver Spring 1 ☐ Yes 2 No MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important if I them 27 is marked other than "nothing or other traumatic connection." USA 20906 Interlochen Drive #511 15101 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 □Yes 2 No Specify: Specify: 包 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't Program Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve M. Cannone Daniel DeMatteo ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code2090619a. Informant's Name/Relationship (Type. Print) 15101 Interlochen Dr. #511 Silver Spring, Md Vivian June Demperio/Sister position
□ Cremation 3 □ Removal from State
□ State S 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remy 11/13/2010 Silver Spring, Md 4 Donation PHIMOTOP ACCEPTION FUNERAL SERVICE, P.A 21. Signature uneral Service Liceris Columbia Blvd.Silver Spring, Md20910 9241 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Vear Month Day 5 Other (specify) 9 Unknown 9 D Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Unknown SRAAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □ Yes 2 🗷 0 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

2

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To the

29c. License number

Les earch

29d. Date signed (Month, Day, Year)

November 9.201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Angela Davis Vovember 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IVISTA ledica Lata enter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6/12/1958 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖺 F Days Months DC 578-80-7692 52 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show the Madical Experiment he rolllled at Director X⊓Yes 2 □No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 Whistling Court 20601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗵 No þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Mangones. Federal Government Contract Specialist Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Steven Yesco Brown, Sr. <u>Breatice L. Kitt</u> 19a. Informant's Name/Relationship (Type. PrintHusband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory D. Davis, Sr. Whistling Ct. Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington
National 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/16/2010 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee cc0278 3831 Georgia Ave. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributions of resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s autopsy performed? 1 □ Yes 2 **X** No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of injury (Month, Day, Year) After th funeral 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural n 24 hours after death.

Re Funeral Director: Afte bletely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 24 29b. Signature and title of celtifier 29c. License number

Hobas

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State #17 TM 11/19/10 Kent Co. Amend Item Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 255 ComeT 4b. City, Town, or Location of Death **Examiner** 4c. County of Death QUEEN AMVES QUEEN ANNES If Under 1 Year Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Min. KENT CO. MO **Director** fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director QUEEN ANNES 1X Yes 2 No 10g. Citizen of What Country? Completed by Funeral TILGHMAN AVE. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) DIXM Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED FURNITURE FURNITURE AUCTION Be 17. Father's Name (First, Middle, Last) Deaton 18. Mother's Name (First, Middle, Maiden Surname) မ INTON SR BESSIE DUIS THERESA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 TURNER 390 SWAMPRD WORTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 11/13/2010 4 ☐ Donation ← ☐ Other (Specify) PLEASANT CEMETER MILLINGTON, MD 22. Name and Address of Facility 855 HIGH ST CHESTERTOWNIND BENNIE SMITHFURFRAL Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEAN (ANA L Lund CAREEN. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 G this certificate has been signed by the ral director, page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 1 🗌 Yes 2 🗌 No Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ieral Director; After filled in by the funer 1. Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of DV-025V NOVEMBIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGNITIONA AVG. GALCESTO AD 21676 MI のりのらでア 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 10,2010 Physician/ Laura Ann Davis 1:30am [™] Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1622 Fallowfield Court Crofton Anne Arundel 9. Birthplace (State or Foreign Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 10-15-1963 Maryland Months 1 🗆 M 2 🗙 F 219-86-4759 47 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No Crofton Anne Arundel MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21114 1622 Fallowfield Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗙 No þ Maryland 21215-0036 1 ☐ Yes 2 Ze No Specify: Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Charles Robert Davis Beverly Ann Bowie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7721 Twin Oaks Way, Laurel MD. 20723 <u> Dana Andrew Davis / Brother</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Sther (Specify) 11-11-10 Baltimore ,MD. Metro-Crematory Signature of Funeral Service Lic 22. Name and Address of Facility Beall Funeral Home Hwy, Bowie Md NW one that cau, ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on ea in the 23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on ea Approximate val Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transition that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy cate has 1 Tes After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending death. Accident Investigation 24 hours after deatle Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completed (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Sia Date signed (Month, Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De		nd Mental H	ygiene	38291
		_	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	1	Reg. No.	
	Physicia Medic		Helen M. Distad		2. Date of D Month Noven	iber 10, 201	3. Time of Death 11:36 AM
	Examin		4a. Facility Name (if not institution, give street and number) 3500 Enterprise Rd.	4b. City, Town, or Location of Mitchellvi		4c. County of Dea	
	Funeral Director		5. Social Security Number 475-07-9774 6. Sex 1 □ M 2 ዻ 7. Age (In yrs. last birthday 92 Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of B Min. (Month, I May 4,	Day, Year) Co	rthplace (State or Foreign ountry) SCONSIN
	*		Usual Residence of Decedent			1.112	
	/land f sho	to	10a. State 10b. County 10c. City, Town or 1				10d. Inside City Limits
	Mar 28a- otifie	ire	MD Prince George's Mitchel				1 🗌 Yes 2 🔀 No
	vith the 23a or st be n	Funeral Director	10e. Street and Number 3500 Enterprise Rd.	10f. Zip Code 20721		10g. Citizen of What C	ountry?
	tems	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Original	in? (Specify Yes or No		erican Indian,
36	after d	Completed by I	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates	If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	Puerto Rican, etc.)	Black, Whi Specify:	te, etc. White
8	hours natura ical E	lete	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most		16b. Kind of Business	
215	in 72 le. han "r	dwo	Elementary/Seconday (0-12) College (1-4 or 5+) life.		,		
7	ygien ygien her ti	(a)		memaker	· · · · · · · · · · · · · · · · · · ·	Own Home	
Maryland 21215-0036	be filed antal H ked ot c ever	To B	17. Father's Name (First, Middle, Last) Henry Scholzen	e, Maiden Surname) .rtz	*		
ary	nd Me			iling Address (Street and Number			ip Code)
Σ	nd 2 st salth a n 27 it er tra		Janet E. Sherbert / Daughter 290	5 Chaney Rd.,	Dunkirk,	MD 20754	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dis cemetery, cr	oosition (Name of ematory or other place)	Date	20c. Location - City o	r Town, State
tim			4 □ Donation 5 □ Other (Specify) Cedar H	.11 Cemetery 22. Name and Address of Facility		Suitland,	MD
Bal	permi Depar Impo any ir once		21. Signature of Funeral Service Licensee	neral Home owie, MD 20	0715		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or part failure. List only one cause on each line.				Approximate Interval Between
-	hysician/	8.7	Immediate Cause (Final disease or or didition a. Alsheimeri	Disease			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	ate be executed physician and the burial-trans it	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):				
0	be exe sician burial	dical	Testing in death, East				
1200	icate l g phys	1 edi					
89 ×	r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of de	
Box 687	requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Other (specify)		Month	Day Year
P.O.	that th	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
ds,	quires en sign ould be	ted t	Hyperkension		1]Yes 2☐No 3☐F	Probably 4 Unknown
COL	law rec has be- je 2 sho	Completed by	Coronary ortery descess		24a. Wa	opsy prior to	utopsy findings available completion of cause of
Be	t The	Co				formed? death? s 2 No 1 7e	s 2 🗆 No
ital	sician certif irecto	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Legation 2 ER/Output	26. Place of Death	`		
of V	g Phy er this eral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time			sidence 6 Other (Spe how injury occurred	city)
on	ttendin death. ctor; Aft y the fur	fical	1 Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 1	No		
Division of Vital Records,	I or Att after d Directe	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		(Street and Number or Ru own, State)	ıral Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occ	curred at the time, date	and place, and due to the	cause(s) and manner stated.
	To the within 2 To the сотре	Ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date a 29c. License number	and place, and due to	the cause(s) and manner as 29d. Date signed (Mont	
			Jaward Muller D	D002660	7	November	15 2010
11	110		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Cullen 4188 OXON Hill 1	B. DXON H	1/ MD	20145	
	Stat Registra	te	31. Date filed (Month, Day, Year) NOV 15 2010 32. Registrar's Signature				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink finsure All Copies Are Legible.

Amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willena Louise Dorsey November 14, 20 TO 4:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Care & Rehab Center Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth
Jan. 27, 1923 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Days Hours Min. 87 New Jersey 137-12-8600 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 6921 Doublebrand Court 21704 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam Specify: White 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than ", Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home 12 or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Holloway Catherine Bird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6921 Doublebrand Ct., Frederick, MD 21704 pernit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Leslie W. Dorsey / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)
Kesthaven
Memorial Gardens 20c. Location - City or Town, State November 18 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part T. Enter the disiane, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failer. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin and transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 V No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform Yes 2 No certificate 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the t 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature PLAYEEY BOLMAUN, MO of person who completed cause of death (Item 23a) (Type, Print) MO 21702. TJ DUNE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ November 22, 2010 Mabel Faye Dohm 12:504 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Egle Nursing and Rehabilitation Center Lonaconing Allegany 8. Date of Birth (Month, Day, Year) September 14, 1917 9. Birthplace (State or Foreign Country) Maryland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 X F 215-14-6285 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57 Jackson Street 21539 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Caregiver Home Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Jesse Dell Dohm Bertha Lee Dohm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Nicol - Niece 14 West Hanekamp Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date November ± 5 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. West Virginia Human Gift Registry Morgantown, West Virginia 22, 2010 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A snamal 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list operations if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician dedetached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe alkisonis. certificate 1 Yes 2 KNo funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29d. Date signed (Month, Day, Year)

State

Registrar

20

Douglas five Lana Coning, Mariland 21539

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 29

				Please	Type or Pri									•
		4	For State		State of M	arylanc					Mental Hy		711111	38294
			Registrar 1. Decedent's Name	(First Middle 1 a	et)		Cei	tificate	e or D	eatri	2. Date of D	Reg. N	ó O I O	3. Time of Death
	Physicia		FLOREN			7					Month	, D	ay - 2010	8:55PM
-	Medic Examin				e street and number)			4b. City,		Location of Death		4	c. County of Deal	
1	j		Coastal	14030104		Lak				lisbuc	Y		Wico	
	Funeral		5. Social Security Nu		Sex 1 □ M 2 X F	e (In yrs. las	it birthday) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	rth a <i>y, Year)</i> 19	Co	thplace (State or Foreign untry) ARYLAND
	Director		218-28-1 Usual Residence of I			77					DEC. 4	1.5.	32 1	
	land show dat	tor	10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🔽 No
	Mary 28a-i	Sirec	MARYLAND	WORCES	TER	I	BERLIN	10f. Zip	Code			10a C	Citizen of What Co	
	be filed within 72 hours after death with the Maryland antal Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Exam <u>iner must be notified at</u>		10e. Street and Nurr 98 ABBYSH)			10.1.2.1	2181	.1			USA	
	eath w	nue	11. Marital Status		12. Was Decedent Armed Forces?		13.	Was Deced	dent of His	spanic Origin? (Sp n, Mexican, Puert	ecify Yes or No)-	14. Race - Ame Black, Whit	
98	fter de	ᅙ	1 Never Marri		1 Yes 2 X			1 🗆 Yes			, , , , , , , , , , , , , , , , , , , ,		Specify:	WHITE
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25.2	withir giene her tha	ပို	12				LIA	ISON					ERAL GOV	ERNMENT
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₹ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or 28a-f sho aumatic event, the Medical Examiner must be notified at		ARTHUR 19a. Informant's Na				19b. Maili	ina Address	s (Street a	CARR and Number or Ru				ip Code)
⊋و	and 2 should the Health and Me tem 27 is mark		SHARON L.							ST., REAL				
Florfnet Baltimore, N	of Hear of Hear fitem		20a. Method of Disp	osition	Removal from State		ace of Dispermetery, cre	osition (Nar matory or c	ne of other plac	e)	Date	20c.	Location - City o	r Town, State
J. in	Page ment tant: I		4 Domation	5 Other (Spec	cify)	CREM				RVA 11/	12/10	DEI	MAR, DE	LAWARE
Florfne Baltimore,	permit, Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		21. Sign turn of P	eral Service Lice	Hart					ss of Facility FUNERAL 1	HOME S	FI.RV	VII.I.E. T	E 19975
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33	Pnysician	S 17	shock, or hear Immediate Cause (disease or condition	Final	one cause opeach lin	CNA	UT	LUI	Va	CARCIN	our			Onset and Death
	Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):			- / // - /				
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09		Physician/Medical			d									
687	ertifica ding p	/We	IF FEMALE: 23b. Was decedent	- recursort	23c. If yes, outcom								23d. Date of d	elivery
ŏ	atten	iciar	in the past 12		1 ☐ Live Birth 4 ☐ Pregnant	at time of d		□ Ectopic □ Other (s)		cy 		_	Month	Day Year
B	the de by the	hys	9 Unknown		9 Unknown			darbija	enuno di	von in Part I	OS- Die	l tabasa	a uga contributa i	to the cause of death?
9.	s that igned be de	5	Part II. Other signif	ficant conditions	contributing to death	but not res	unung in ine	underlying	Cause gi	verriiri aiti.				Probably 4 Unknown
rds	equire	eted									24a. W		24b. Were a	utopsy findings available
Division of Vital Records, P.O. Box 68760	e law e has b	Completed									pe	rformed	dogth?	completion of cause of
<u>=</u>	an: Th tifficat tor, pa	Be	25. Was case referrexaminer?	red to medical						lace of Death (Ch		3/ 2 (110	
Z.	hysici his cer	<u>ا</u>	1 🗆 Yes 💅	No			ER/Outpati			4 L Nursing	Home 5 🗆 Re		Ţ.	ecify) HOSPICIZ
Joh	Jing P	ate:	27. Manner of Deat	5 Pending	28a. Date of in (Month, D	jury Pay, Year)	28b. Time injury		28c. Injur worl		28d. Describ	e now in	jury occurred	
<u></u>	Attencr deatl	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigat 6 Could no determine	t be 28e. Place of Ir	njury - At ho	me, farm, s				28f. Location	Street own, Sta	and Number or F	ural Route Number,
Divi	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Ce			bullding, 4	etc. (Specify					10			
	Hospi 24 hou Funer ited fill	Medical	(Ob)	O Bendinal For	hysician: To the best miner: On the basis of urse Practioner: To th	avamination	and/or inve	setination in	a my onini	ion ideath occurred	at the time, dat	e and nla	ace, and due to the	e cause(s) and manner stated
	o the vithin 2 on the	ž	only the)		urse Practioner: 10 tr	ne best of m	y knowleage	20	c Licens	e number		29d.	Date signed (Mor	
	rs+ o	29. Signature and title of certifier 20. Signature and title of certifier 20. Signature and title of certifier 20. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cituatur was Proposition (Name 23a) (Type, Print) 21. Data filed (Month Pay Year) 22. Pagistrar's Signature								0				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUMAN (1) AA SE PO BOP 1733 SAUG BULL (ILL) Y/80 C									1207				
	V		31. Date filed (Mon	- 0-7.	32 Regis	trar's Signa	ture	1/-	<u> </u>	3/109	suc	7	ill)	40-0
	Sta Regist				1010 Len	-	b. 4	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0058 Hattie Mae Dennard 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner Dorchest ambidge General Hospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🛣 F 90 220-01-7964 MD Director 06/22/20 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Cambridge Dorchester MD 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 United States 520 Glenburn Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and Mental Hygiene. 1 □ Never Married 2 □ Married Dennard Hの中々 い. Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: Black þ 3 ₩ Widowed 4 Divorced "natural", Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, The Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Manufacturing Laborer 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Mae Bell Carr Charles Jackson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Hubert St. Apt. B, Cambridge, MD 21613 Theresa Dennard/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Church Cem. 12/01/10 Vienna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, PA 21. Signature of Funeral Service Licensee Eskon Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 50 disease or condition resulting in death) hours /Medical Due to (or as a cons a uence of): Examiner um Sequentially list conditions, if any, leading to immediate cause. Enter Unicertying Cause (Disease or injury that initiated events.) Due to or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 😘 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe After this certificate funeral director, pan 2 200 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 → Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death

1 Accident 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after weare.

To the Funeral Director: After the funeral py the f 1 🗆 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar a

A

30. Name and address of person

31. Date filed (Month, Day,)

60:5

an

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D. 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Of Way
Registrar 11/19/10 M.S. Kent Co. Amended#10f Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Emma Elliott Mary 11 2010 Medical 10:50A Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospotal Center <u>Chestertown</u> Kent Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗆 Director 212-18-1 9l1 6 <u>-671</u> MD Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified 1 Yes 2 No Millington Queen Anne's 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 220 Spring RD 21657 21651 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 6 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 1 Yes 2 No Specify. Il Hygiene. other than "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Process VegetaBLES Salisbury Brothers Be 17. Pather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Charles Hines Sara Augusta Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u>Valerie Elliott</u> 5134 Daughtei Airey's Baltimore, RD Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ← Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pleasant UM Church /24/2010 Chestertown, 21. Signature of Juneral Service Lig Ceme Le IN I'm Yand Address of Facility Bennie SmithFuneral Highe Streetertown. Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be an each line. Approximate Interval Between Onset and Dezill Immediate Cause (Final Physician/ Ogeas Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Day to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 1 Yes 2 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has ; page 2 s autopsy death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗀 No by the 1 Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) M.D D0017036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ko mo State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Diana Lynn Evans Vear Physician/ 0757 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center umberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days June 15 1965 1 🗆 M 2 🔀 F Months Hours Min West Virginia 213-86-0032 45 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Allegany Westernport MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 United States 421 Hammond St. Aprt. 111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 white 1 Yes 2XNo Specify: Hygiene. other than "natural", If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 Is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ James Evans Louella Rider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14800 Broadway St, Cresaptown, Maryland 21502 Catherine Tipton/ friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/26/2010 cemetery crematory or other place)
Cumberland Crematory 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home Man 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHE Sequentially list conditions, if any, leading to immediate cause. Enter or runnying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed AMI and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an has page 2 autopsy After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: မ 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1/ Natural 5 Pending injury death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 WILLOUBROOK MAN.

Registrar

State

32. Registrar's Signature

			Please T	ype or Print i				-	•			
			For State Registrar	State of Mary		artment of F ertificate of		entai Hygier Reg. N		00000		
			Decedent's Name (First, Middle, Last)					Date of Death	6010	3. Time of Death		
10	Physici /Medio		Frances	Leaman	E	nglehorn	0	ctober	272010	2307 M		
	Examir	er	4a. Facility Name (If not institution, give s	~ 1 1		I act	r Location of Death	4	c. County of Dear	th		
	Funeral		5 Social Security Number 6. Sex		yrs. last birthday	If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	Tal bo	thplace (State or Foreign		
L	Director			M 2 🗗 8'	7 Yrs.	Months Days	Hours Min.	7-22-1923	CT.	ountry)		
	land ow		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or L	ocation				10d. Inside City Limits		
7	e Mary la-f sh	ctor	FL. Miami- Da	de	Homeste	ad				12X Yes 2 ☐ No		
	with the Maryland 3a or 28a-f show	al Dire	455 S.E. 21st. La	ne		10f. Zip Code 330	33 :.	10g. 0	Citizen of What Co	A.		
၂ ၂	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Marical Examina. The bandling at once.	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	dispanic Origin? (Specian, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.		
21215-0036	thours		3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	edent's Usual Occup	pation	16b.	Kind of Business/			
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and	d be fill ental F ced ott	Be c	17. Father's Name (First, Middle, Last) Walter E. Lea	nan			18. Mother's Name (,			
Maryland	should and Me mark umatio	卢	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mail	ing Address (Street	and Number or Rural	Route Number, City	or Town, State, 2	Zip Code)		
Z,	and 2 sealth au		James C. Hinckley				St. Orland					
Baltimore,	ages 1 nt of H : if ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	and a cold from Chata		matory or other place		1	Location - City or			
Itin	nit. Pa artme ortant injury E.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cremato:		-2010 Sa1				
B	Dep Imp any onc		Tiosoph m. Ost	rowsk. C	F.50	P.O. Box	Šstrowski l 518 St. Mic	runeral H chaels, M	ome P.A. d. 21663			
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause each line.	nsequence of):	ter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onser and Death 5 days		
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
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rds, P.	e law requires that the de has been signed by the le 2 should be detached		Part II. Other significant conditions con	ributing to death but no	_	inderlying cause giv	en in Part I.	23e. Did tobacco		the cause of death? obably 4 Unknown		
Division of Vital Records,	iclan: The law re certificate has bev ector, page 2 sho	Be Completed by	25. Was case referred to medical				26. Place of Death (24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of		
> ¥	Physic this ce al direc		examiner? 1 ☐ Yes 2 ☐ No	ospital:	2 ER/Outpatie		er: 4 ☐ Nursing Home	e 5 ☐ Residence	6 □Other (Spe	cify)		
ou c	ding P. After 1 funera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Ye.	ar) 28b. Time o	Worl		d. Describe how inj	ury occurred			
Division	l or Attendatter deatl Director:	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined M 1 ☐ Yes 4 ☐ Homicide Description M 1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours To the Funeral completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of meer: On the basis of exa and manner stated.	y knowledge, dea amination and/or i	th occurred at the timestigation, in my o	me, date and place, an opinion, death occurred	nd due to the cause If at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)		
	To th Within To th	Me	29b. Signature and title of certifier	1 100		29c. Licens		29d. E	ate signed (Mont	h, Day, Year)		
			I Malitat Pesi	per NOV		D56	2251	1	0/29/10			
	10+31	6	30. Name and address of person who com	npleted cause of death	(Item 23a) (Type,	Print)	Carat (1 4.02	Easton	MODULO		
	Sta Registr		31. Date filed (Month, Day, Year)	npleted cause of death ther M 32. Registar's S	Signature	Market .	war I	July 1) MILOURO		
	ricgisti	all a	14() % 0 0 0	- June	- p.	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 3 A M 2010 Medical 4a. Eacility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Hospita heverl Georges ince If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, 8. Date of Birth **Funeral** 83 Days (Month, Day, Year 1 M 2 M Months Hours Min. Country) ica astern MD Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location Examiner must be notified at Director 1 Yes 2 No anham Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5 **23**a Funeral Echol Stat 26701 united permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. I hours after death w Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in ILS 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemake Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) dward ughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Riverdale Park Crematory NOV. 12,2010 Kiverdale 4 Donation 5 Other (Specify) 22. Name and Address of Ficility e of Francial Service Licenses Services ion And Fruneval 5732 GA NW Wash DC 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ oCardia disease or condition resulting in death) HOURS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months Month Year 5 Other (specify) Pregnant at time of death been signed by the s 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 HNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? 1 Yes certificate Yes 2 INO 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 100 1 🗌 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA ည within 24 hours after death.

In the Funeral Director: After this campleted filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Matural 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registra

31. Date filed (Month, Day, Year)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** JOHN SOMERS FISHER, JR. 2010 5:30 p^V November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care-The Pines Talbot Easton Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday **Funeral** 1**X**M 2□ F Months Davs Hours Min 10/03/1921 218-22-6095 89 VA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at any Injury or other traumatic event, the Modical Examinar must be notified at once. 1XYes 2 ☐ No Funeral Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 UNITED STATES 312 WINTON AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: WHITE <u>Ş</u> 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER ENGINEERING** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAISY KETCHUM JOHN S. FISHER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY E. FISHER/DAUGHTER 312 WINTON AVE., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MEADOW RIDGE CEMETERY 11/06/2010 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PERIPHERAL Physician VASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed end burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Worknown icate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate Vital 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1□Yes Z⊟No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death

Natural

2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred r Attending Division 5 Pending investigation s after death.
I Director After on by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2

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State Registrar

CENP 32. Registrar's Signature 31. Date filed (Month, Day,

- CRNP

29c. License number 3333k 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIO DUTCHMANS CANT

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 25 per med cert G910 12/1/1/19 dk
State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 11:454M nom. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Le LANC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Oct 21, 1945 1**火** M 2 □ F Months 219-42-7712 65 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland or items 23a or 28a-f shov 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 X Yes 2 No Salisbury Wicomico MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21801 403 Bailey Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White etc. African-Armed Forces?

1X Yes 2 \(\subseteq \) No Army à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. American Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Food Manufacturer Data Processor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Beulah M. Shreeves Samuel C. Fontaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bailey Lane, Salisbury, MD 21801 Lessie R. Fontaine/wife 403 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 11/6/2010 Westover, MD 4 ☐ Donation 5 ☐ Other (Specify) John Wesley UMC Cem 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Road, Salisubry, MD Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or an a consequence of) Examiner ension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine ete To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 🗗 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONAHUW MD 32. Registrar's Signature State yeared. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3, 2010 November 18. 2:26P M Madeline Fiori Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months Days Hours Min. (Month Day Mary Land Director September 23. 22-12-3706 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Market Street 21629 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐X No Black, White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White and Mental Hygiene. Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11 H.S. Grad. College (1-4 or 5+) Cafeteria Worker High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Maddox Fountain Marv Emma Cohee permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joan Elliott/niece</u> 355 Market St., Denton, Maryland 21629 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Nov. 23, 2010 | Bridgeville, Delaware 4 Donation 5 Other (Specify) Bridgeville Cemetery Signature of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Paysician/ Vascular disease or condition resulting in death) bro Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Abo
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year the hed 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l page 2 s autopsy performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗆 No within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

31. Date filed (Month D State

MD

Wafik Zaki,

920 Market Street, Denton, Maryland Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doo47534

21629

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Novemb 6^{Day} 201^Y0 Griffin Physician/ 9:05 A M James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Silver Spring Montgomery 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Hours 89 VA 224-22-9742 2 /189/1¹²9/2°I° Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Funeral Director 1 🔀 Yes 2 🗆 No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1380 Fort Stevens Dr. NW #104 20011 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ukn. Black 3 Widowed 4 Divorced "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Data Entry Supervisor Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Thomas Griffin Lydia Caprew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Milliard C. Griffin/Son Crittenden St. NE Washington, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hampton, VA 11/24/10 Hampton Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee cc0278 Georgia Ave. NW Washington, DC 20011 3831 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Anterio Schenoth ₽nysician/ GARDIOVASCULA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying and al-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Respiratory tailur autopsy performed' 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	aryland / Dep			∕lental Hy	giene	2010	00005
			_ State Registrar		Ce	rtificate of L	Death		Reg. No	ZUIU	38303
	Physicia	n/	Decedent's Name (First, Middle, La Rosa Virginia					2. Date of Dea		9, 2010	3. Time of Death 10:45A M
	Medic	al	4a. Facility Name (if not institution, gir			Ab City Town o	r Location of Death	Novembe			·
	Examin	er	Gilchrist Hosp:	Towsol				. County of Death Baltimor	е		
34	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign
	Director		230-30-0718	1 □ M 2 🔀 F	84 Yrs.	Months Days	Hours Min.	Sept. 2	9,19	26 Virg	inia
	d ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits
	ryland I-f sh ied a	cto	MD No. County			timore				1	1 🔀 Yes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code				tizen of What Cour	ntry?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "matical Examiner must be notified at	eral	1039 Horners La	ne		212	05			USA	
	tems tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No-		14. Race - Americ Black, White,	
36	", or i	by	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No	1 ☐ Yes 2 🔀 No			l		√hite
21215-0036	ours a stural	Completed	3 X Widowed 4 Divorced 15. Decedent's	Year or Dates.	16a Dece	edent's Usual Occup	nation		16b K	ind of Business In	dustry
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212	within /giene. ner tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5	Sh.	ipping De	pt		G]	ass Comp	any
	filed valued by all Hyg	Be	17. Father's Name (First, Middle, Las)			18. Mother's Nam	ne (First, Middle, Hanshel	Maiden	Surname)	
ylaı	uld be file Mental narked c	2	Stephen Shupe								
Maryland	and is n		19a. Informant's Name/Relationship Wilda Reier-Avil			ing Address (Street	and Number or Rui	ral Route Numbe	r, City oi d Bi	r Town, State, Zip (candywine	, MD 20613
	and 2 s Health tern 27		WIICA RETEL-AVII	es/Grandda	20b. Place of Disp					ocation - City or To	
סר	nt of l		1 Burial 2 K Cremation 3	Removal from State	cemetery, cre	ematory or other pla ematory,	TNC NOVE	ember 11 2010		altimore	
Baltimore,	permit. Page Department Important: It any injury or		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice			CREMATION		2010			
Ba	Depar Impor any ir		from 60	Phila		495 Ritch		Sever	na P	ark, MD	21146
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	nplications that cause	d the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	202	isc SI	Voc					Onset and Death
~~	Medical Examiner		resulting in death)	a. Due to tenas	a consequence of):						
7	Exammer	Je .	Sequentially list conditions,	b. 200	115						
	sit a	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to to as	a consequence of):	7 1.	Pech	191			
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0	be executed sician and burial-transit	cal		d d			-				
6876	Attending Physician: The law requires that the death certificate or death. setor: After this certificate has been signed by the attending phy. the funeral director, page 2 should be detached for use as the								T		
39	endin	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth	2 Fetal death 3	☐ Ectopic pregnar	ncy			23d. Date of deliv	
Box	death he att ed for	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death 5	Other (specify)				Month	Day Year
P.O.	at the d by t letach	Completed by Physician/Med	Part II. Other significant condition	contributing to death I	out not resulting in the	underlying cause g	iven in Part I.	23e. Did t	obacco	use contribute to t	he cause of death?
	res that signer	db	Chippic	do unal	foiled	ul		1 🗆	Yes 2	No 3 Pro	bably 4 🗆 Unknown
ğ	requi been should	lete						24a. Was		24b. Were auto	psy findings available
ဝင	e law e has ige 2	Ĕ						auto perfe 1 Yes	ormed?	death?	ompletion of cause of
E E	an: Th tificat tor, pa	Be C	25. Was case referred to medical			26. F	Place of Death (Che			10 103	2 110
Vita	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2X No	Hospital:	ient 2 🗆 ER/Outpati	ent 3 DOA	her: 4 Nursing H	lome 5 🗌 Resi	dence	6 Other (Specif	Hospice
Division of Vital Records,	ng Ph ter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injudenth, Da		of 28c. Inju		28d. Describe	how inju	ry occurred	1
lon	eath. or: Af the fu	lfica	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	4 5 0			Yes 2 □ No		101-11	(A)	I Davida Number
ViS	or Att after d Direct in by	Certificate:	4 Homicide determin	28e. Place of In	iury - At home, farm, s c. (Specify)	treet, factory, office		City or To	wn, State	nd Number or Rura e)	ir Houte Number,
	Hospital 24 hours a Funeral E		29a, Certifier 1 Certifying P	hysician: To the best o	f my knowledge, deatl	occured at the tim	ne, date and place, a	and due to the ca	ause(s) a	nd manner as stat	ed.
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Charle O Mandinal Eve	aminer: On the basis of lurse Practioner: To the	evernination and/or invi	ectication in my onin	nion death occurred	at the time, date	and piac	e, and due to the c	ause(s) and manner state
	To the within To the comple	2	29b. Signature and title of certifier				se number			ate signed (Month,	
1			1	= M.	6.		7128-	1	11	9/10	
	η_{μ}		30. Name and address of person wi	no completed cause of	death (Item 23a) (Type	, Print)). O.	-	1		21204
	1/2		RWWD -Cha	neen 67	01 1/4 (LIGHT YELL	st. Ste	4(07)	D9	1 Unes	' DM'

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Ple .	ease Type or Pr State of N				k. Ensure / Health and I	-	_	ble.
		State Registrar			Cer	tificate of	Death	T	Reg. No	0 38306
Physicia		1. Decedent's Name (First, Midd Delia T. Greg	•					2. Date of Dea Month Novem	Day	3. Time of Death
Medic Examin		4a. Facility Name (if not institution	on, give street and number))			r Location of Death		4c. County of	f Death
Funeral		9406 48th Plac 5. Social Security Number	6. Sex 7. A	ige (In yrs. la	ast birthday)	If Under 1 Year	e Park I If Under 24 Hrs.		h	nce George's 9. Birthplace (State or Foreign
Director		577-56-5622		0	Yrs.	Months Days	Hours Min.	12/28/	1939 I	E1 ^{cowitty} lvador
and show	tor	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City	, Town or Loc	cation				10d. Inside City Limits
Maryl 28a-f otifiec	irect	Maryland Princ	e George's		Colle	ge Park				1 X Yes 2 □ No
vith the 23a or st be r	Funeral Director	10e. Street and Number 9406 48th Plac	`e			10f. Zip Code 20740			10g. Citizen of Wh	nat Country?
death v items ner mu	Fune	11. Marital Status	12. Was Decedent			Vas Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race -	- American Indian, White, etc.
al", or	d by	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	arried 1 Tyes 2 X				Specify:E1			White
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ithin 7; iene. r than the Me	Com	Elementary/Seconday (0-12)		r 5+)	life. Do	o NOT use retired, maker)	9	Но	ome
filed w al Hyg d othe) Be	17. Father's Name (First, Middle							Maiden Surname)	
ould be d Ment marke	입	Moises 19a. Informant's Name/Relation	Arrue Mejia	<u> </u>	401 14 15	411 (2)			a Aguilar	
d 2 sho alth an 1 27 is or traus		Francisco D. G		and	1	_	and Number or Ru ace, Coll			
per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. In product if items 23 a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	on 3 Removal from Sta		lace of Dispo	sition (Name of natory or other pla		Date	20c. Location - C	City or Town, State
nit. Pag artmen ortant: injury e.		4 Donation 5 Other 21. Signature of Flores Survives		Kal		ematory Name and Addre	11/1			er, Maryland neral Home
per nii Der ar Imp or any in once.		>/Illlulle						_		, MD 21037
		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final	or complications that cause t only one cause on each li	ed the death ne.	n. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	a. Due to (or as	AOIO s a consequ		an cer				months
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ited	Examiner	if any, leading to immediate Cause (Disease or iinjury	Due to (or as	s a consequ	ence of):					
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ending r use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar	ncy Ideath 3	Ectopic pregnan	CV		23d. Date	· ·
res that the death certificate I signed by the attending phys d be detached for use as the I	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknowr	at time of d		Other (specify) _			Mont	h Day Year
that th	by Ph	Part II. Other significant condi	itions contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to		ute to the cause of death?
requires been sig should b	eted							1 🗆 🗎		Probably 4 Unknown
e law r e has b ige 2 si	Completed							24a. Was a autop perfo	sy pri rmed? de	ere autopsy findings available or to completion of cause of ath?
sician: The law r certificate has b lirector, page 2 s	Be C	25. Was case referred to medical examiner?					lace of Death (Chec	1 🗆 Yes	2 4 No 1 L	Yes 2 No
ding Physician: h. After this certific funeral director,	욘	1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien	t 3 DOA Oth	4 L Nursing F	T	ence 6 Other	
anding sath. rr. After	ficate	1 Natural 5 Pend 2 Accident Inves	ding (Month, D stigation		injury	wor	k? Yes 2 No	Zad. Describe in	ow injury occurred	
or Atte after de Directo in by th	Certificate:	3 Suicide 6 Coul 4 Homicide deter	rmined 28e. Place of Ir	njury - At ho etc. <i>(Specify)</i>		et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate in within 24 hours after death. with 124 hours after death. The Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical		ng Physician: To the best of							
thin 24 thin 24 the Fu	Med		ng Nurse Practioner: To th				ne time, date and pla	ace, and due to the	cause(s) and man	
6 ₩ 6 0		Page 2	en Batus 1	$\mathbf{M} \cdot \mathbf{D}$			50678		29d. Date signed (i	
17.		30. Name and address of person	on who completed cause of	death (Item						
† U .	e	Rajeev Batra, 31. Date filed (Month, Day, Year)	32. Regist	New trar's Signat	Hampsh ure	ire Ave.	, Ste. 30	00, Silv	er Spring	, MD 20904
Registra		NOV 1	4 = 0040	reve	B. A	park				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ Arthur T. . Gross 2010 8:38 Medical 4c. County of Death a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner icomico Peninsula Regional Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Months Hours Min. 81 175-24-3313 Director 07/23/1929 Pennsylvania Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland rector 1 Yes 2 X No Maryland Tyaskin Wicomico 듑 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21865 IISA 4506 Tyaskin Road **Examiner must** items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) mechanical engineering engineering 12 Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Amie Robert Stanley Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary F. Gross/spouse 4506 Tyaskin Rd., Tyaskin, MD 21865 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 11/17/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Spow Hill Rd., Salisbury, MD 21804 LE eral Service Li art I. Enter the disease, or complications that cau led the lock, or heart failure. List only one cause on exhibite. leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 \square Pending Natural 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Salisbury

Carroll St.

mD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

coura

rne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Physician/ 2010 3:00 William Terry Holmes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 05 02, Country 1944 Director 164-34-4505 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Garrett Swanton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 23a Funeral 18 Frederick Circle 21561 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) contractor building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Chalmer Holmes Leona Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau Rita J. Holmes Frederick Circle, Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory: 11/24/2010 _Cumberland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility David A. Burdock Funeral Home P.A Oakland, MD 21550 2nd St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and D, at shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cironary Vascular
Diseus Pnysician Medical resulting in death) Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last tending physician are use as the burial-Completed by Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į, in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page 2 s autopsy performed 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ٩ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge. 29b. Signatu 29d. Date signe (Month, Day, Year) 10 31. Date filed (Month, Day, Year) Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Day C Month NOV 1154 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death university of maryland medica Baltimore Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 8. Date of Birth 1 M 2 12 F 06/23/1929 **Director** 81 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2X No TALBOT MD **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12214 OCEAN GATEWAY 21601 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 👿 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 👿 No Specify: Specify: WHITE "natural" Completed 3 **K** Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SUPPLY CLERK **TELECOMMUNICATIONS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þe JOHN W. McCARTY LOUISE V. GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra PEGGY L. MENDE/DAUGHTER 11288 BUTLER ROAD, DENTON, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 $\fill \square$ Burial 2 $\fill \square$ Cremation 3 $\fill \square$ Removal from State 4 $\fill \square$ Donation 5 $\fill \square$ Other (Specify) cemetery, crematory or other place, SPRING HILL CEMETERY 11/18/2010 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 MERLER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year q Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Montl Florence Hall October | 26, 2010 1:36 pm M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TE Months Days Hours Min 10/25/1922 Pennsylvania Director Yrs 578-18-6415 88 Usual Residence of Decedent 10b. County ural", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 20902 Unite States 901 Arcola Avenue death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Black 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 1 Retail permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tam any injuly or other traumatic event, the Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mami Unknown Scott Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 U Street, North West, Washington, D.C. 20001 Victor Brown/Son Baltimore, 20a. Method of Dispesition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Byrial 2 🛣 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/8/2010 Beltsville, Maryland 21. Sig t re of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. <u>7400 Georgia Avenue, N.W. Washington,D.C.</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Acute Myocardial Infarction Medical resulting in death) Examiner Sequentially list conditions, many, bearing to intributate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a sonsequence or). and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the a Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has bage performed 1 Yes 2 No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Hospital 2 🕱 No Other: 욘 1 🗌 Yes After this 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending s after death.

I Director: Af 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral C Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examine 3 ☐ Certifying Nurse To the within 2 To the I only one) 29b. Signature and title of 29c. License numbe

Registrar

State

Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

31. Date filed (Month, Day, Year,

NOV 16 2040

D09834

October 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Eugene Hawk Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death WMHS-Regional medical Alleaan Cumberlar Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 29 Birthplace (State or Foreign Country)
 WV 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Min. Director 234-46-7041 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director WV Elk Garden Mineral 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 26717 RT 1 Box 19A USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) miner coal industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nellie Cosner Dewey Hawk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Bobbi Jo Hanlin-daughter Rt 1 Box 19A, Elk Garden, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrett Co Memorial Gardens Oakland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility David A. Burdock Funeral Home P.A 21 N. 2nd St, Oakland, MD 21550 23a. Pary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 13 neumonia 1 (aleval disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No this certificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director. / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number Nov 19 2010 DOU 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Ave, #101 Cumberland, MD 21502 Sunil Gupta

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Year 3:45 A M Hanlin Leon 2610 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HIODMICO REGIONA2 SALISBUR TENINSUULA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Min West Virginia Director 82 213-24-7207 Usual Residence of Decedent show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27121 Crooked Oak Lane 21830 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 X No Specify: White 3 Widowed 4 X Divorced Specify: 1975 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Navy Chief US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Burgi Hanlin Relin Bessie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health aitem 27 i <u> Ardys Marie Lewis – Sister</u> Crooked Oak Lane, Hebron, Maryland 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Page 1 and Important; If ite 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) 11-17-201b Crematory of Delmarva Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home ark 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Vrivan Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of After 28d. Describe how injury occurred Natural 5 Pending injury Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: A Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009

B

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O

2010

P.R.M.C.

32/Registrar's Signatur

Lucur

obert A. Coker,

31. Date filed (Month, Day, Year)

17005619

100 E. Carroll St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 10:18 PM **JEANNE** LOCKNANE ITJEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Hours 218-56-4389 59 8 102 11 951 Washington.DC **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No WV Jefferson Harpers Ferry 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? nit. Page 1 and 2 should be filed within 72 hours after death with t attrement of Health and Mental Hygiene. advants if item 27 is marked other than "natural", or items 23a ortants if item 27 is marked other than "hatural", or other traumatic event, the Medical Examiner must be injury or other traumatic event, the Medical Examiner must be Funeral 25425 United States 450 Shenanwood Drive 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【☐ No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosary Eloise Wilcox James Marshall Locknane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shenanwood Dr. Harpers Ferry, WV 25425 <u>Donald_Itjen/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smith Sburg 11/29/10 | Smithsburg, MD Crematory

Lefferson Chapel Funeral Home

Jefferson Chapel Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence on) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed Yes 2 No B B Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ᇛ 2 No 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of certifier 29d. Date signed (Month, Day, Year) D0063498 11/20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wadhwa Lakhvinder 400 W 7th St Frederick, MD 21701 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

DIL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#8perFH, 11/16/10, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30, 2010 Alice Dorothy Jones Oct. 7:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. *Aug 16,1927 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Days Hours 83 Director 577-32-8581 South Carolina Usual Residence of Decedent 28a-f show 10a. State Oc. City, Town or Location **Washington** the Medical Examiner must be notified at 10d. Inside City Limits Director D.C. 1 🗆 Yes 2 🌁 No 10e. Street and Number ō 10f. Zip Code Citizen of What Country? USA "natural", or items 23a Funeral 20011 4701 Colorado Ave., NW hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Limore, Maryland 21215-0036 Specify: Afro-Amer. If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Education Teacher Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Rosa Lee McCaskill Jones Melvin Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 Firestone Dr., Silver Spring, MD 20905 Hildegarde Sylla cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 11/12/10 4 Donation 5 Other (Specify) Suitland, MD, Lincoln Memorial Signature of Funeral Service Licensee 22. Name and Address of Facility

McGuire Funeral Service, Inc.
7400 Georgia Ave., NW, Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Bladder Cancer disease or condition resulting in death) Medical Examiner months End-stage Renal Disease Sequentially list conditions. Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bone metastases, lung metastases, peripheral 1 Yes 2 No 3 Probably 4 Munknown vascular disease - both legs. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 10 N 2 1240 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Aupanich, RSM, MD D 0065485 11/01/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Ann Supanich, MD 1500 Forest Glen Rd., Silver Spring, MD 20910

State

Registrar

Barbara Ann Supanich, MD

NOV 16 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JENKINS HNITA :50 AM Medical Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 □XF Months Hours (Month, Day, Year) Director 94 MD` -31-1916 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 🗆 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7739 Waterview Lane 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Giv 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Russell Phillips Anita Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthias Manly Jenkins-husband 7739 Waterview Lane Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 11-5-2010 Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Retween Onset and Death Immediate Cause (Final Physician SUSPECTED LUNG MALIGNANCY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of,: g physician and is the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year been signed by the s should be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HEART CONGESTIVE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 No 1 🗌 Yes 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 of death (Item 23a) (Type, Print) 31. Date filed (Month

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0-434M Doug 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett (uni OAKLAND Garrett Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Funeral 1 🔀 M 2 🗌 Months Hours Min. Feb. 8, 1947 63 500-48-4693 MD. **Director** Usual Residence of Decedent show 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d, Inside City Limits Director 0akland MD. Garrett 1 A Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #7 Liberty Square U.S.A. 21550 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 See 2 No 1967 Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No 3 Widowed 4 M Divorced Specify: Completed White 1969 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be t. Page 1 and 2 should be filed rument of Health and Mental Hy rant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hicks Betty Fred Douglas Jackson Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1559 Gneev Church Rd. Oakland, MD. 21550 19a. Informant's Name/Relationship (Type, Print) 1559 Gnegy Church Rd. Danny Jackson (brother) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o 1 Burial 2 S Cremation 3 Removal from State 11/20/10 Cumberland, MD. Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility D. A., Burdock, Funeral Home, P.A. 11.2nd. St. Oakland, MD. 21550 21N.2nd. St. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ANTERIOSCUEROTIC COMENANY VASCULAN DIGO Year Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or selectiones on) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

Registrar

DHMH 17 Rev 7/2009

State

Dr Oakland

eleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ざい Beatrice P. Quillen Jefferson 1158 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center alisbur WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5-19-1917 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Months Days Hours Min. Director 221-03-7026 93 Maryland Usual Residence of Deceden show "natural", or items 23a or 28a-f sho 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 🗌 Yes 2 💢 No Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 1110 Healthway Drive, #109 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. th and Mental rrygien... 27 is marked other than "natural" "" animatic event, the Medical Ex 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 11 <u>Homemaker</u> ermit. Page 1 and 2 should be filed wi epartment of Health and Mental Hygie nportant: If item 27 is marked other by injury or other traumatic event, II Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Washington Savage Quillen, Jr. Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Jefferson - Husband 1110 Healthway Drive #109, Salisbury, MD 2180 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or otl Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fellows Cemetery 11-20-2010 | Milford, Delaware Odd 21. Synature V Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Tue to (or ea a consequence ory: if any leading to immediate cause. Enter Underlying Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. -transit Cause (Disease or linjury that initiated events ending physician ar r use as the burial-t Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Ö in the past 12 months? Month Day Year n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed aortic aneurysm 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 Mo 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗙 No 1 X Inpatient 2 ER/Outpatient 3 DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Babulal

31. Date filed (Month, Day, Year)

XX a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

100 East

CARROLL ST. SALISBURY Med 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 28a-f per me, g910,12/27/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2327 2010 Nora T.ee Jones Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Peninsula Regional Salisbur(Wicomica Medical conte If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🖺 F Days Hours 01/29/1928 213-22-8283 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Wicomico Hebron 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 303 S. Main Street 21830 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 K Married "natural", or <u>Ş</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) loan officer financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry T. Nuttall Eliza G. Caulk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other tra 303 S. Main St., Hebron, MD 21830 Eugene Jones/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State Springhirm Medicryce 11/22/2010 4 Donation 5 Other (Specify) Hebron, MD Gărdens 21. Signature of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCV D Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): ischemic 405)(ble Sequentially list conditions. Examine Due to (or as a consequence oi) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ omplicators Completed 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) æ Hospital 1 XXYes 2 □ No Other: ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 🛣 No injury Natural 5 Pending To the ruce within 24 hours after completed filled in by the f-completed filled in by the f-10/18/2010 Subject fell 2 Accident **Unknown**^M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office At home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 303 S. Main St., determined Hebron, MD Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of by knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 45049 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25h 11/15/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL ST. SALISBURY MIDZINOI Cheistopher Snyden Do DME Nate SAN MD 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1816 Briggs Rd.	Silver	Spring	İ	Montgom	erv
	Funeral		1816 Briggs Rd 5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthd.	y) If Under 1 Year	If Under 24 Hrs. 8, Dat	e of Birth nth, Dav, Year)	9. Birthr	lace (State or Foreign
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	or ite	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	If Yes, specify Cubar	spanic Origin? (Specify Yes ı, Mexican, Puerto Rican, e	tc.)	14. Race - Americ Black, White,	
9	I and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Heath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed b	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No	Specify:		Specify: Whi	te
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EE)	permit. Page 1: Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee Kurt Blake	Edward sage	of Facility el Funeral D: Llle Pike Roc	irectio	n Inc	
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Hoen	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion	, death occurred at the time	, date and place	e, and due to the cau	se(s) and manner stated.
4	vithin dithin	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifying	ge, death occurred at the 29c. License			(s) and manner as sta ate signed (Month, D		
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	5		30. Name and address of person who completed cause of death (Item 23a) (Typ		1545	NOA	ember 11.	2010
			Piyush K Patel M.D. 19745 Executiv	e Park Cir.	Germantown,	MD 20	874	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 23:35P. M 2. Date of Death Physician/ November 10, 2010 John Klim R. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Takoma Park **Examiner** 4c. County of Death Montgomery Washington Adventist Hospital 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 192–20–7528 Sex 1X M 2 □ F **Funeral** Months Days Hours JW177124 1927 Pennsylvania Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Beltsville Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 4403 Sellman Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?

1 Ves 2 No Black. White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White It Yes, Give Year or Dates 1951-1952 Specify Completed 3 X Widowed 4 Divorced 16b. Kind of Business Industry Washington, DC Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene.
7 Is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Metropolitan Police Dept. Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mary Turchen Joseph Klim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4403 Sellman Road Beltsville, Maryland 20705 John R. Klim, II -son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Casimir's Cemetery 11/20/2010 1 X Burial 2 Cremation 3 Removal from State St. Muhlenburg, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens id V. Borgwardt Funeral Home, Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as of ac or respiratory arrest. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **Medical** Due to (or as Examiner Sequentially list conditions Examine cause (Disease or linjury Due to for and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a cons attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use centribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completic death? this certificate 2 X No 1 Yes 25. Was case referred medica examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2,2 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) r of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural Natural 5 Pending n 24 hours after death, e Funeral Director: Afte bleted filled in by the fun Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune
completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 0 +30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7701 Carroll Avenue Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

NOV 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11 5 Day **Physician** 2010 MARY CAMPBELL KING 7:55 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOT HEARTFIELDS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 💢 F Yrs 89 08/04/1921 WASHINGTON, DC Director 224-48-6605 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1X Yes 2 □ No Director VA **ALEXANDRIA** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 22302 614 WEST BRADDOCK ROAD Funeral UNITED STATES filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 X No Specify þ WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME th and Mental Hygie 7 Is marked other to other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ELLIOTT CAMPBELL BESSIE RAMSEY ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health SARAH KING/DAUGHTER 5337 ULMER ROAD, BELLEVUE, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION 11/08/2010 CENTER Department o Important: If any injury or once. Ξ ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 21. Signature of Funeral Service Licensee MERCERO N 200 S. HARRISON ST., EASTON, MD 21601 LOH0 R. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** of Alzheimuris My pe 10 Organic /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Its some paragraph of the Examiner physician at the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1. Natural 5 Pending 1 □Yes 2 □No illed in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8579 Commerce CKAP-31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town or Location of Death Examiner 0 (44) 184 NUVI If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 12/28/P1930 Months Days NewTork 79 076-24-7760 1 X M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21044 United States 6334 Cedar Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Mermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Sylvia Cohen Jack Leckner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13818 Arctic Avenue Rockville MD 20853 Ira Leckner - brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial
Gardens 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 11/7/2010 Falls Church, VA 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20582 21. Signature of Funeral Service Licensee M01163 Approximate Interval Between Onset and Death 23a. P -11. First the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown Part II. Other significant copiditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 🔲 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending Injury To the Hospital or Attendir
Within 24 hours after death.
To the Funeral Director: Af 1 Tyes death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division or Vital Records,

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day,

36. Name and address of person who completed cause of death (Item 23a) GWM

and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For State Registrar	State of Maryl		artment of H tificate of E			giene Reg. No 2 (110	380	323
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~ . ~			7733 Bridle Path (5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	ederick			Freder	ace (State o	u Countino
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	or 28	吉	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
	with s 23a ust b	Funeral	7733 Bridle Path	Circle		21	701		USA			
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ē,	f Heal	U	20a. Method of Disposition	201	o. Place of Dispos		. !	Date	20c. Location	n - City or Tov	vn, State	
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المسهدية	Physician/ Medical cian and nurial-transit	lical Examiner	23a. Part Enter the dileast, or complications that carl ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760	s tha gnec se de	by Physician/Med								23d. Date of delivery Month Day Year obacco use contribute to the cause of death? Yes 2 XNo 3 Probably 4 Unknown		
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:	the Hi nin 24 the Fi hplete	Mec	(Check 2 Medical Examiner only one) 3 Certifying Nurse P	ractioner: To the best of	my knowledge, de	eath occurred at the	time, date and p	place, and due to the				ner stated.
	No To To	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)										
7						1000	1113		11/	12/3	2010	
	5		30 Name and address of person who com NAVEEN BOLALUM	leted cause of death (It	em 23a) (Type, Pr	int) EAFLILL	MA	21702	•			İ
	Stat	e_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature #	1	/					
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j	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of	
	/		University of Moryland Medical Center Baltimore		,	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24 F Months Days Hours M	lin. (Month, Da	th y, Year)	9. Birthplace (State or Foreign Country) New Hampshire
-	Director		003-38-5560 59 Yrs. Usual Residence of Decedent	Ди1у 16	,1951]	New Hampshire
	yland -f show ed at	ctor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ✓ Yes 2 No
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336	s after al", or Exami	d by	1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No If Yes, Give Year or Dates. 1973–90 1 □ Yes 2 ☒ No Specify:		Specify:	White
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	1 and 2 s of Health item 27		Taeok Y. Lacroix/ Wife 5015 Logan Street, F 20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
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Baltimore,	permit. Page Department or Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown			
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9289	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	e of delivery
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P.O.	at the d by th	Phy	g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
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	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place	e, and due to the ca	use(s) and manner	r as stated.
	the Ho hin 24 the Fu	Mec	(Check only one) 3 ☐ Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and	place, and due to th	e cause(s) and mar	nner as stated.
	vit Vo		29b. Signature and title of certifier		29d. Date signed	(Month, Day, Year)
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	60	11 (1	3 /10
1	otIUA		Maurice Agringonery UMMC 22 south Greene ST.	Boltimos	e MD	21201
	Stat Registra		31. Date filed (Month, Day, Year) NOV 17 20 0 Januar B. Januar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Physician/ Year 715 Loring Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico alisb Ponincula Regional Medical Year If Under 24 Hrs. 9. Birthplace (State or Foreign cial Security Number B. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year Country) 1 X M 2 - F Director 512-34-5795 <u>Kansas</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 28a-f 1 X Yes 2 No MD Wicomico Salisbury 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 209 N. Park Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 5 þ Yes 2 X No Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Campbell's Soun Distribution Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ruth and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Mark Loring - Son 32508 Old Ocean City Road, Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-17-2010 Delmar, Delaware Crematory of Delmarva! 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ASCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death
Unknown Yes 2 No the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed death? To the Hospital or Attending Physician: The certificate 2 N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ပ 1 Inpatient 2 -ER/Outpatient 3 DOA teral Director: After this filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' Natural 5 Pending 1 Yes 2 No death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted within 24 h To the Fur Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

31. Date filed (Month,

lorcan

Day, Year)

O

Carroll STREET

who completed cause of death (Item 23a) (Type, Print)

3 001

32. Registrar's Signature

WO

MIS 53825

29d. Date signed (Month, Day, Year) 12/10

Salisbury MD Z1801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Sylvester Leon Lockwood Physician/ Month 9 2010 1:40 P November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Funeral Days Min. (Month, Day, Year) 6-30-1924 1 💢 M 2 🗆 F 86 Director 220-26-1211 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 XNo MD Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8314 Patey Woods Road 21841 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpeciBlack "natural", 3X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Newport Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Artie Lockwood Ukn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8827 Marshall Creek Rd, Newark, MD 21841 Verdell Shaw/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Williams AME Cem 11-15-2010 Newark, MD 22. Name and Address of Facility 917 W. Isabella St. 21. Signature of Funeral Service License Funeral Home Salisbury. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician cardioundas disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burlal-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 🗌 No 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 1 ☐ Yes 2🌠 No s after deam. ral Director. After this cerus. In by the funeral director, p? Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 131285 November 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Bernal-Clark, CRNP 9715 Healthway Dr, Berlin, 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV Registrar

		For State Registrar	State o	f Maryland		irtment o		and M		giene Reg. Ne)	383	27
Physicia		1. Decedent's Name (First, Middle, Wilma	, Last)		Le	wis	_		2. Date of De Month	ath Day	Year 2010	3. Time of E	
/Medica Examine	er	4a. Facility Name (If not institution, The Johns Hopkins		nber)		4b. City, Town	n, or Location o				unty of Death		
Funeral Director		5. Social Security Number 216-56-2171	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da	ear If Under ays Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 02/21,	†† 1951	9. Birth Cour Mar	place (State or try) yland	Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Directo	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 🕱 Divorced	12. Was Dece Armed Fo	2 X No /e			of Hispanic Or Cuban, Mexica		ecify Yes or No Rican, etc.)	14.	Race - Americ Black, White,		
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permit. F Departm Importar any injur		21. Signature of Funeral Service			- 22 F	Name and A	ddress of Facil Y Funer W Hill	äl H	lome Pro	ofessi bury,	onal A MD 218	ssociat 04	ion
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7, MT		30. Name and address of person Mohamed	Elsha	zly				600	North W	olfe St,	Baltimo	re, MD,	21287
Sta Registr		31. Date filed (Month, Day, Year) NOV 18	2010	Registrar's Signati	9. Apo	uks							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November DAVID CRAIG MOORE T1, 2010 4:55 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery . Sex 1 Å M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 272-28-7055 **8**5 Months Hours Sept. Day Year 1925 West Virginia Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Gaithersburg Montgomery 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 333 Russell Ave. #423 20877 United States filed within 72 hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give WWII
Year or Dates. 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed who...
with and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barclay W. Moore Julia Hammon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Martha A. Moore (Daughter) 7224 Millcrest Terrace Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery crematory or other place) ě 1 Burial 2 X Cremation 3 Removal from State Noy0103, Metropolitan Crem. Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityDeVol Funeral Home Millian 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Conjestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy 6 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ing physician and se as the burial-transit Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hypertension Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Atrial Fibrillation page 2 autopsy performe death? certificate Yes 2 X No 1 Yes 2 No Physician: **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys is within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? X Natural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signaty e and itle of certifier 29c. License number 29d. Date signed (Month. Dav. Year 10+1 R093435 November 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phyllis Jones CKNP 201 Russell Ave. Gaithersburg, MD 20877 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 15, 2010 **MERVISH** Jeanne 5:40 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Ochtonth, 9ay, Year910 9. Birthplace (State or Foreign Funeral Days Months Hours 1 DM 2 X Min Hartford, CT 577-28-1294 100 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant I free 223 or 28a-f show that I free 27; is marked out than "natural", or items 23a or 28a-f show jury or orther traumatic event, the Medical Examiner must be notified at. City, Town or Location Rockville 10a. State 10b. County 10d. Inside City Limits Director Montgomery MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 6121 Montrose Rd. 12. Was Decedent Ever in U.S . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
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If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Dry Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hyman Sara Kantrowitz Denenberg 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2130 Taney town Pike, Taney town, MD 21787 Sara Lowe niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 A Burial 2 Cremation 3 Removal from State akeside Mem. Park Doral, Florida Nov.17,2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full eral kervice Licen 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 № No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 68 pleted cause of death (Item 23a) (Type, Print 30. Name and address of person who com

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 pay 2010 Edward James Matthews Nov. 5:56 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P.G. Southern Maryland Hospital Clinton Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral №** M 2 🗆 10-1-29 wash. DC Director 81 578-36-2398 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville MD. P.G. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 6050 Sargent Road U.S.A. 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dry Cleaner Private Service 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Sullivan Rachel Lucille Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 6050 Sargent Rd. #5208 Hyattsville, Md. Dorothy W. Matthews/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Quantico Nat Cem. 11/19/10 Triangle, Va. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Hackett's Funeral Chapel, <u>814- Upshur Street, NW</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 515 Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 0-5500 Sequentially list conditions, e attending physician and for use as the burial-transit Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed butter and a constant of the Funeral Director. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the a d be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 13/10

		_	State of Maryland / De	epartment of He Certificate of De			2010	20221
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of De	eatti –	2. Date of Death	g. No.	3. Time of Death
	Physicia Medic	al	Arlette Jean McGil			Month	4, 2010 Year	4:30a M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Lo			4c. County of Deatl	
			9808 Summit Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		sington	8. Date of Birth	Montgo	nery hplace (State or Foreign
	Funeral Director		5 7 7 - 4 2 - 4 0 9 1	Months Davs	Hours Min.	(Month, Day, Y	1925	Intry) France
	and show lat	5	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Maryl 18a-f tified	ec	Md Montgomery Ke	nsington				1 ☐ Yes 2🛣 No
	a or 2	<u>=</u>	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	untry?
	h with	Funeral Director	9808 Summit Avenue		0895		USA	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	 Was Decedent of Hisp If Yes, specify Cuban, Yes 2 No 		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh i	e, etc.
Baltimore, Maryland 21215-0036	nin 72 hour ne. ihan "natu e Medical	Completed	(Specify only highest grade completed) (G Elementary/Seconday (0-12) College (1-4 or 5+)	ecedent's Usual Occupati ive kind of work done dur e. DO NOT use retired)		ng 1	6b. Kind of Business I	
72	d with hygier ther t	0		memaker			Own Hon	ie
anc	be file ental F ked o	10	17. Father's Name (First, Middle, Last) Arthur Amoudruz	['		e (First, Middle, Ma ene Sei	,	
Mary	2 should th and M ?7 is mar traumati			ailing Address (Street and				
ē,	f Healt f Healt item 2 other		20a. Method of Disposition 20b. Place of Di	sposition (Name of		Date 20	Oc. Location - City or	
<u>iii</u>	Page ment c ant: If ury or			crematory or other place) of Heaven metery	NOV 20	io ¹⁷ s	ilver Sp	ring, MD
Balt	permit. Departi Import any inj			22 Name and Address 500 Univer	of Facility J. Coll rsity B	ins Fun Ivd. W.	eral Hom , Silver	e Inc. Spring, M
	Physician/ Medical Examiner		23a. Part 1. In the rithe disease, or complications that cau and the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerot Due to (or as a consequence of):	ic Cardio				Approximate Interval Between Onset and Death
		ıminer	Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or injury) Alzheimer's D Due to (or as a consequence of: An emia	ementia				
09	ite be executed hysician and he burial-transit	dical Exa	that initiated events resulting in death) Last Due to (or as a consequence of): Lymphoma					
. Box 68760	Attending Physician: The law requires that the death certificate be executed are death. The death certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	very Day Year
Division of Vital Records, P.O.	res that the signed by the detact	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given	n in Part I.		cco use contribute to	the cause of death?
scord	law require has been si ge 2 should I	Completed				24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
m m	Physician: The law this certificate has al director, page 2		25. Was case referred to medical	26 Place	e of Death (Check	1 🗆 Yes 2		2 🗆 No
/ita	slciar certi irecto	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Other			ce 6 🗆 Other (Speci	
of \	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury a		me 5 □ Hesiden 28d. Describe how		TY)
no	andin ath. ir: Aft	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injut 2 ☐ Accident Investigation		es 2 🗆 No			
Division	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town, S	et and Number or Rur State)	al Route Number,
_	e Hospit 124 hour e Funera	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, dear only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinion,	, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
	vithii To th	-	29b. Signature and title of certifer	29c. License n			d. Date signed (Month	
	5		De Service	D522	2.47		Nov. 15,	2010
	_		30. Name and address of person who completed cause of death (Item 23a) (Typ Collin Cullen, MD 7625 Wisc	e, Print) onsin Ave.	., Beth	esda, M	D	
	Star Registra		31. Date filed (Month, Day, Year) NOV 16 2010 32 Registrar's Signature	all				

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:10 A^M 2010 Edward Paul Martuszewski November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oueen Anne's Co. 112 Woodstock Road Chestertown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Funeral Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours (Month, Day, Yea 09/13/192 Country) Marvland Director 216-20-4213 83 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🔀 No Queen Anne's Co. MD Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Woodstock Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 1 950-1952 White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Fabricating Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Paul Martuszewski Juatina Lucy Jusck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Regina Martuszewski - Wife 112 Woodstock Road Chestertown, Maryland 21620 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Find Important: If ite 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, 11/19/2010 Cemetery Hurlock, Maryland VA 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility Fellows, Helfenbein & Newnam Funeral Home, any 30 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Caranoma withhetostasis to tepatocellular disease or condition Medical resulting in death) Due to (or as a consequence of): PORTACAVAL NODES Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. à signed by the period of the period of the details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Were autopsy findings available prior to completion of cause of 24a, Was an has autonsv page death? certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗷 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending iniury thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🖲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 11/16/10 23889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 High Street CHESTER HOWN, Wed 21620 MID. 31. Date filed (Month, Day, Year) 32. Regis Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Montgomery November 2010 11:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Cecil 84 Grey Fox Drive 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) MD If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min. May 31, Year 1919 1 🕅 M 2 🗆 F Months Hours 91 Yrs Director 216-28-6263 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ano.e. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director E1kton 1 Yes 2 X No MD Cecil 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 84 Grey Fox Drive 21921 IISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Mae Harris Harry Stern Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 84 Grey Fox Drive Elkton, MD 21921 Jewelyne Montgomery/ wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/2372010 1 ☐ Burial 2 ☐X remation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
R.T. Foard Funeral Home
259 E. Main St. Elkton, Home, 23a. Part 1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between eset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) as a consequence of Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as ERLIPIDEMIA To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed certificate ha 2 🗆 No Yes 25 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours at To the Funeral Discompleted filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day. Year) 30. Name and address of person who complete NOV 22 31. Date 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	110 00001
1. Decedent's Name (First, Middle, Last) 2. Date of Death	
	3. Time of Death
/Medical JULIE MICHELLE MOREL NOVEMBER 7, 20	010 8:00 A M
Latitude	ty of Death LBOT
Funeral Director 5. Social Security Number 6. Sex 1 M 2X F 6. Sex 1 M 2X F 6. Sex 7. Age (In yrs. last birthday) 6. Sex 1 Months Days Hours Min. 1 M 1 M 2X F 1 M 1 M 2X F 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	9. Birthplace (State or Foreign Country) WASHINGTON, DC
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MD TALBOT TRAPPE 10e. Street and Number 10g. Citizen of	1 □Yes 2 X No
10e. Street and Number 10f. Zip Code 10g. Citizen of 29505 PORPOISE CREEK ROAD 21673 USA	f What Country?
29505 FORPOISE CREEK ROAD 21073 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra 15. Big	ace - American Indian,
If Yes, Give 1 □ Yes 2 No Specify: Speci.	ack, White, etc. ify: WHITE
1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HO HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surna.	
17. Father's Name (First, Middle, Last) LINUS PRYCE HAYES 18. Mother's Name (First, Middle, Maiden Surna. GLADYS HARRISON	ame)
Elementary/Secondary (0-12) 12 0 HOMEMAKER OWN HO RICHARD A. MOREL, HUSBAND 19a. Informant's Name/Relationship (Type. Print) RICHARD A. MOREL, HUSBAND 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Plant of the part	
20a. Method of Disposition 20a Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) 20c Location 20c CHESAPEAKE CREMATION 11/9/2010 STEVEN 20c CHESAPEAKE CREMATION 11/9/2010 STEVEN 20c CHESAPEAKE CREMATION 11/9/2010 STEVEN 20c CHESAPEAKE CREMATION 11/9/2010 STEVEN 20c CHESAPEAKE CREMATION 20c Chesapeake 20c Chesape	n - City or Town, State
21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNE	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	G YEARS
Examiner Sequentially list conditions, b.	
if any, leading to immediate Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Comparison of the constructio	
O T T T T T T T T T T T T T T T T T T T	
The standard of the standard o	Date of delivery Month Day Year
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continuous properties of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continuous properties of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continuous properties of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continuous properties of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	ntribute to the cause of death? 3 Probably 4 Unknown
in bear of the state of the st	o. Were autopsy findings available
autopsy performed 1 □ Yes 2 No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
F g g b g g g g g g g g g g g g g g g g	12100 2210
Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 DO 27 Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occur	
S	uneu
27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c.	nber or Rural Route Number,
5 5 5 E	manner as stated.
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and replace and manner stated.	e, and due to the cause(s)
P + 2 2 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	e, and due to the cause(s) ned (Month, Day, Year)

State

Registrar DHMH 17 Rev 1/2001

DAVID H. SMITH 31. Date filed (Month, Day, Year) NOV 09 2010

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KATHERINE SEDGWICK MASDEN OCTOBER 31, 6:00 P M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11399 KITTYS CORNER ROAD **CORDOVA** TALBOT 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Date of Birth **Funeral** Vear Months Days Hours Min 1 □ M 2**X** F 214-28-1862 82 Yrs Director 2/16/1928 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits fshow ir than "natural", or items 23a or 28a-f shorthe Medical Exercises is unit be notified at Director 1 ☐ Yes 2 X No MD TALBOT **CORDOVA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11399 KITTYS CORNER ROAD 21625 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify WHITE \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 LINE WORKER POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I WILLIAM SEDGWICK FLORENCE GAY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health at: If item 27 is DEBORAH MARIE HUGHES, DAUGHTER 218 PARDONERS TALE LANE, FELTON, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) SPRING HILL CEMETERY | 11/5/2010 4 Donation EASTON, MARYLAND 21. Signature of FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** BREAST 8 yrs Le noth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and I-tran physician a s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical attending p for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes : After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner* Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) Certification: Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the ft. death. Accident 1 Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D39887 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID H. SMITH 8221 TEAL DRIVE, STE. 301, EASTON, MD 21601

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) - State Registrar Amended item#1&17, WCHD, SLU, Certificate of Death 11.17.10 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dena E. Maddox Month Day Year Physician/ 9:38 M 010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICOMIC SAUSSYLL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6 – 1 – 1 9 5 6 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 1 □ M 2 🛛 F 54 MD Director 219-62-9286 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Heatth and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10h. County Director 1 XYes 2 No MD Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21853 30721 Division Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Our Future Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည <u>Louise Hyland</u> Uku Emerson Lee Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St. Princess Anne MD 21853 <u>Divisio</u>n Thomas Maddox/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-13-2010 Princess Anne, John Wesley Cem 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Signature of Funeral Service License any or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Externe disease or complications that caused shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 Remove diable list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last aftending physician Physician/Medical Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year Month in the past 12 months?
1 Yes 2 No for Pregnant at time of death been signed by the a should be detached Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s Yes 2 X No 1 Yes 2 No certificate 25. Was case referred to medical exerciner?

12 Yes 2 1 No 26. Place of Death (Check only one) Division of Vital To the Hospital or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA မ this funeral 28a. Date of injury (Month, Day, Year) 28h Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nyrse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu 00 8

Registrar
DHMH 17 Rev 7/2009

State

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Registrar's Signature

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Camil Street

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21801

MD

SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2010

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NUV 17

31. Date filed (Month, Day, Year)

Physician Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. miller, ANDRE Baltimore, Maryland 21215-0036 Physician Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	State of Maryland / Dep	artment of Health and N rtificate of Death	Mental Hygiene Reg. No. 2	10 38337
	Registrar 1. Decedent's Name (First, Middle, Last)	Timodio of Doda.	2. Date of Death	3. Time of Death
1/	Andre Earl Miller		Month Day	2010 3:07AM
aı er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. Count	ty of Death
	Doctors Community Hospital	Lanham		ice George
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F F 7 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	219_62_8925		10-9-1956	I NC
ō	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
rect	MD Prince George Lanham			1 X Yes 2 □ No
	10e. Street and Number	10f. Zip Code	10g. Citizen of	f What Country?
nera	9516 Washington Blvd.	20706	USA	
F	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ace - American Indian, ack, White, etc.
d b	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X No Specify:	Spec	Mack
Be Completed by Funeral Director	15. Decedent's Education 16a. Dece	dent's Usual Occupation	, 16b. Kind of I	Business Industry
μŭ	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work OO NOT use retired)		
Ö	Elect	tronics Owner		Employed
To B	17. Father's Name (First, Middle, Last)	i	ne (First, Middle, Maiden Surnan	ne)
_	Octave James Miller		Lee Gaines	01 to 750 Octob
		ing Address <i>(Street and Number or Rur</i> 6 Round Road , B		1100 112
		osition (Name of T.T.C matory or other place)		- City or Town, State
	4 Donation 5 Other (Specify)	Crematory, 11-2		
	21. Signature of Funeral Service Liponsee	2. Name and Address of Facility 917 Ennie Smith	W. Isabella	a St.
	23a, Part 1, Enter the disease, or complications that caused the death. Do not enter	uneral Home Sal ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	lesporatory.	ferlure	Interval Between Onset and Death
	resulting in death) a. Due to (or as a consequence of):	VENTAG ON	1	
<u>_</u>	Sequentially list conditions, b.	UCS PATTI		
m i	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury	ric Stoo	· .	
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dical Examiner	CAR.	MAGORMOIC	47.	
Med	IS SCHAIG.			
an/I	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		Date of delivery
sici	1 Lyes 2 Lino	Other (specify)	N	Month Day Year
To Be Completed by Physician/Me	g Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use cor	ntribute to the cause of death?
db	, an in Calc of G .	, , ,		3 Probably 4 Unknown
ete			24a. Was an 24b	. Were autopsy findings available
mp.			autopsy performed?	prior to completion of cause of death?
ပို	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 No	1 Yes 2 No
0 B	examiner? 1	Other:	ome 5 Residence 6 Ot	ther (Specify)
T :	27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how injury occu	
fica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No		
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
Medical Certificate:	29a. Certifier (Check only one) 1	stigation, in my opinion, death occurred	at the time, date and place, and c	due to the cause(s) and manner stated.
2	29b. Signature and title of certifier	29c. License number	29d. Date sign	ned (Month, Day, Year)
	ms			111 7010
	30. Name and address of person who completed cause of death (Item 23a) (Type, Azecz Abiodun 8118 Good Luck	Print) ROAD LANHAM.	ma anda	
e			110 20 106	
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			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of			eg. No. 2010	38338
	Dharain		1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat	th Day Year	3. Time of Death
	Physici /Medi		Mabel Gene Me					Vovemb	per 15 201	
	Examir		4a. Facility Name (If not institution, gi		_	_	r Location of Death		4c. County of Dea	
Series .	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs	B. Date of Birth (Month, Day, May 31,	Year) 9. Bir	thplace (State or Foreign ountry) aryland
	Director		215-20-1826 Usual Residence of Decedent 10a, State 10b, County		84 Yrs.	ocation		May 31,	1926 Ma	10d. Inside City Limits
	e Maryla la-f shov tified at	ctor	Maryland Carolin	ıe	Denton					1 AYes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	
	s 23a	eral	319 S. Second St	reet 12. Was Decedent	Ever in II S 42		1629	ify Ven or No	U.S.A.	
396	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:		If Yes, specify Cub	dispanic Origin? (Specan, Mexican, Puerto F Specify:	ican, etc.)	Black, Whit	te, etc.
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121	lould be filed within I Mental Hygiene. Tarked other than Tatlc event, the Me	m C	Elementary/Secondary (0-12)	College (1-4or 5	5+) _	cretary	u)		Law	
<u>d</u>	illed Hygi other ent, t	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's Name	(First, Middle, I	Maiden Surname)	-
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Maryland	2 should I and Men is marker		19a. Informant's Name/Relationship	(Type. Print)	1				r, City or Town, State,	. ,
	Pages 1 and 2 ment of Health ant: If item 27 i ary or other tre		James W. Merrike	n, Jr./son					ne, Maryla	
Ore			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3			ematory or other pla	ce)		20c. Location - City or	•
Baltimore,	permit. Page Department o Important; If any Injury or once.	-	4 ☐ Donation 5 ☐ Other (Special Service Lip	ify)		Crematory 22. Name and Addre		/10 1	Dover, Dela	ware
Ba	permit. P Departm Importar any Injus	0. 0	Hawloft	nous_	M	ore Funeral	L Home, P.A.,		nd St., Dento	
			23a. Part1. Enter the disease, or conshock, or heart failure. List onl	nplications that caused y one cause on each li	ne.		ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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90,	oe execian a	I — 1	resulting in death) Last	Due to (or as	a consequence of):					
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P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
	res that igned b	by Pt	Part II. Other significant conditions	sontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Records,	w require: been sig should be	q pa	- Herel	enture				1 □ Ye	es 2□No 3□P	robably 4 nknown
9	law re as bee 2 sho	Completed	Aren	s ,				24a. Was a		utopsy findings available completion of cause of
- B		Som						perfori	med? death? 2 No 1 ☐ Yes	
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or Vital	Phys this al dir	<u>د</u>	1 Yes 2 No	28a. Date of Inju		SIII 3 DOA	4 LI Nursing Hom		ence 6 Other (Spe	ecify)
on	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Wo	rk?]Yes 2 □No	od. Describe in	ow injury occurred	
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ă	ospital or Attend hours after death uneral Director: , ly filled in by the f	Certification:	4 Difficiale	building, et	tc." (Specify)			City or Towl	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical		Physician: To the best aminer: On the basis of and manner st	of examination and/or					
	Withi To t	Ž	29b. Signature and title of certifier	10.0		29c. Licens	se number		29d. Date signed (Mon	
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4			30. Name and address of person wh	completed cause of c	neath (Item 23a) (Type	weg	hurton	Stree	A East	16,2010 ,M)2/601
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Physici		Registrar 1. Decedent's Name (First, Midd						2. Date of De Month		Year	3. Time of Death
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		4a. Facility Name (if not instituti St. Marys Hospital	on, give street and n	umber)	1	lb. City, Town, or Leonardtow		n		County of De Mary's	eam
Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Yea					Birthplace (State or Foreign
Director		215-83-3567	1 M 2 F	2	Yrs.	Months Day	s Hours Min	n. 10/1	6/20	08 1	Maryland
any		Usual Residence of Decedent 10a. State 10b. County			ity, Town or Location						10d. Inside City Limits
	ō	MD st.	Mary's		Leonardt	town					1 Yes 2 No
Maryland r 28a-f sho	Director	10e. Street and Number 22685 Lorest	- Avanue			10f. Zip Code 206	50		10g. Citize	n of What C	ountry?
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2 hours		 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		t's Usual Occupat ost of working life			16b. Kir	nd of Busines	ss/Industry
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical	o Co	17. Father's Name (First, Middle Felipe Bard		 tig			18.Mother's Nam	e (First, Middle Siles	•	,	
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드스워드님		4 Donation 5 Other S		<u> </u>				T DIINE	ד ג כוי	Mexi	ICE,P.A.
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ixaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence	out.						Death
		Sequentially list conditions,	b. Choking or		•						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequence	e of):						
ed isit	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	e of):				-		
executed an and al - transit	= 1	UNPENDED	dAMENDED								
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Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the burings	Physician/Medica	23b. Was decedent pregnant in t past 12 months?	L	oirth nant at time of	death	al death 3 [ner (Specify)	Ectopic pregn	ancy	М	lonth	Day Year
Box 6 e death cer the attendi	hysic	1 Yes 2 No 9 Un	known 9 Unkn		3 Oth	er (Specify)					
, P.O. B ires that the d signed by the	by P	Part II. Other significant condi-	tions contributing t	o death but no	t resulting in the ur	nderlying cause g	given in Part I.			e contribute	to the cause of death?
rds, F requires been sign	ted							24a. Wa			autopsy findings available
cords, e law requir e has been s	Completed							pen	opsy formed?	death	
tal Rec		25. Was case referred to medical	ni			26.Place	of Death (Check		2 No	1 🗸	Yes 2 No
Vital hysician: this certif	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	✔ ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residenc		her
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should		27. Manner of Death 1 Natural 5 Pen	28a. Date (Mont) NoV 7,	of Injury 1. Day Year) 2010	28b. Time of In 1250 hrs		ry at Work? ∕es 2 ✓ No	28d. Describe Choked or			andy
Divisior Hospital or Attend 24 hours after death Funeral Directoretely filled in by the	Certification:	2 Accident Inve	stigation	ce of Injury - Al	t home, farm, street			28f. Location	(Street and	Number or	Rural Route Number, City
Div pital or ours aft eral Di	Serti	Galoide		Single Fa	amily Home			or Town, 22685 Lawre	State) ence Aven	ue, Leona	rdtown, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:			hysician: To the beaminer:On the basis								
	Medical	29b. Signature and title of certific	and manner s	stated.	. anaror myesuyati	29c. Licens					Month, Day, Year)
3		Canal	1/000	0 1-		O.C.I	M.E.			mber 8, 2	
		30. Name and address of persor									
			sistant Medical	Examiner egistrar's Sign		treet, Baltimo	ore, MD 2120)1			
St	ate	31. Date filed (Month, Day, Year)	MAD A	egistidi s Sigh	A COM						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Orellana NOV . 11, 2010 Year D. 1720 Rosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Days Hours 51 218-23-3025 8/30/1959 El Salvador Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Montgomery MD Germantown 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12201 St.Peter Court Apt.B 20874 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: EI Salvador Specify: White Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Accountant Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymundo Najera Marcos Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code20874Kathya Orellana/Daughter 12201 St.Peter Court Apt.B Germantown, Md 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation Parklawn Mem.Park 11/14/2010 Rockville, Md. 5 Other (Specify) uneral Service 21. Signatur PHNETE INPANDES RINALDI FUNERAL SERVICE, P.A. 7 9241 Columbia Blvd.Silver Spring, Md2910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pancreatic Cancer Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion activities. the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 12, 2010D0067512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Medica

Center Drive Rockville, Md 20850

9901

32 Registrar's Signat

Bangalore MD

Madan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Physician/ <u>8:1</u>5A ^M November Pauline Jones Oliver Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kent Heron Point Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral 1 □ M 2 🗓 F Days Hours 12/15/1914 Maryland Director 212-03-8657 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No MD Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 USA 501 East Campus Drive Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan once. 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Co-Owner Millington Mills Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Hollett Charles Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garnet Hill Lane Avon, Connecticut 06001 Charles Shivery - Son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/13/2010 Millington, Maryland Millington Asbury 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral
130 Speer Road Chestertown, Maryland 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician ZHEIMERS DISEASE years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any seeing to immediate cause. Enter Underlying Examine Due to or as a consquence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for to in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART 1 Tyes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation ∟ Acciden □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) D0041587 5 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of p

Registrar
DHMH 17 Rev 7/2009

State

ton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month William Lanning Osterlund 18 2010 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton 309 Melbourne Blvd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye)
Dec. 13, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F Dec. 202-18-0447 82 Yrs Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho Director **Elkton** Cecil MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 Funeral 309 Melbourne Blvd. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 X Married 2 X No þ ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Oscar W. Osterlund Ethlyn Hemmingway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 i 309 Melbourne Blvd. Elkton, MD 21921 Phyllis Osterlund - Wife 20a. Method of Disposition
1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 11/26/10 R.T. Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) Rising Sun, MD 22: Name and Address of Facility 21. Signature of Funeral Service Licenses R.T. Foard Funeral Home P.A. St., Elkton, MD 21921 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ 1ng anc Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown g Unknown P.0. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed I Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 No this certificate 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III W. High St. Ste 104 EIKton, MD 2192

8:00A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

701

Year

1 X Yes 2 ☐ No

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MOV 2 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 10 POVIC Physician/ Vana 11/10/2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5805 Osceola Road B<u>ethesda</u> Montgomery Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 XF Months Hours (Month, Day, Year) Country) 577 54 4557 101 Serbia Director 07/24/1909 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐XYes 2 ☐ No MD Montgomery Bethesda 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5805 Osceola Road 20816 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc 1 Never Married 2 Married Yes, Give X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Andrija Popovic</u> <u>Zivka Isakovic</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other ti Ljubica D. Popovich/Daughter 5805 Osceola Road Bethesda. MD20816 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2010 Washington, DC Creek Cemetery 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Sarvice King 30 Wisconsin Ave., NW Washington. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death within 24 hours after death.

• the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 ☐ Yes ∠ ∟ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 🗌 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🔲 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5- Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of pertifier

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAY LIPPMAN MD 705 DK 17ML

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ ROBERT NOVEMBER 2010 6:43 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 X M 2 - F Months Days Hours Min Oct. 7 1946 64 219-46-6208 Washington, D.C. **Director** Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Damascus Md. 1 🛚 Yes 2 🗆 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 9928 Colorado Court United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Serves 2 No 1965-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Install/Repairman Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parke Mildred Hicks Allison Ralph 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9928 Colorado Court, Damascus, Md. 20872William H. Parke / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 S Cremation 3 Removal from State 11/17/10 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Va. . Signature of Fune al Service Licenses Name and Address of Facility
Muriel H. Barber Funeral Home 20882 0. Box 5038. <u>Lavtonsville</u>, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed physician and the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death ate has been signed by the a page 2 should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Division of Vital Records, 2 🗆 70 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes မှ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

BHUA

29b. Signa

re and title of certifier

NOV

Hemen shah

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65-C

Registrar DHMH 17 Rev 7/2009 homas

Called.

32. Registrar's Signature

060417

29d. Date signed (Month, Day, Year) 11-15-2010

Frederick MD 21702

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State		State of	Marylan	,	partment of ertificate of			•	•	0010		2001 E
		Registrar 1. Decedent's Nam	e (First, Middle, L	.ast)		Ce	eruncate o	Deau	1	2. Date of De	Reg. No			3. Time of Death
Physicia Medic		CHARLE	S LEST	ER POOLE	E					Month NOV.	1.5		- 1	2:45A M
Examin				ive street and number	er)		4b. City, Town		on of Death			. County of De	ath	
Funeral		KLINE H			. Age (In yrs. Ia	ast birthdav	MT. A		ler 24 Hrs.	8. Date of Bin	_	REDER		e (State or Foreign
Director		214-30-		1 ☑M 2 ☐ F	80	-	Months Day			Month, Da	y, Year) 193	0	ountry)	MD
and show dat	٦	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or L	ocation						T _{10d}	Inside City Limits
/arylar 8a-f s tified	recto	MD	MONTG	OMERY		ICKE	RSON							1 ☑ Yes 2 ☐ No
a or 2 be no	ΪΩ	10e. Street and Nur	mber				10f. Zip Cod	е			10g. Ci	itizen of What C	Country	?
th with ms 23 must	Funeral Director		DICKER	SON SCHO			2084		2-1-1-0 (0 -	-16 - May Na		USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Marr3 ☑ Widowed	ried 2 Married	Armed Force	s? □ No195	1-	. Was Decedent of If Yes, specify Co	uban, Mexic	can, Puerto	city Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: V		
hours natur	plete		15. Decedent's		3.	16a. Dec	edent's Usual Occ e kind of work dor		ast of warki	na	16b. K	(ind of Busines	s Indus	try
within 72 giene. ier than ' ;, the Me	Completed	Elementary/Sec		College (1-4	or 5+)	life.	OUNTAN	ed)	ost of workii	ng		SEARCH VELOPN		
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d 2 should alth and h 27 is ma		19a. Informant's Na		(Type, Print) SISTER	-IMAW	19b. Mai 221	ling Address (Stre	et and Num	nber or Rura N SCI	l Route Numbe HOOL R	r, City or D • ,	Town, State, Z	ip Cod	920842 ON, MD
Page 1 and of He ent of He nt: If item y or other				Removal from St	20b. P	emetery, cr	position (Name of ematory or other p			Date 7 / 2 0 1 6		ocation - City o		
permit. F Departm Importa any injul once,		21. Signature of Fu					22. Name and Add	dress of Fac	cility	Р	.0.	BOX 8	36	•
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Examiner		Sequentially list co	nditions	,		,	R ACCI	DENT					1	week
d sit	Examiner	if any, leading to in cause. Enter Under	nmediate rlying	Due to (or	as a consequ	ence of):								
xecute n and al-trans	Exar	Cause (Disease or that initiated events resulting in death) I	S	c. Due to (or	as a consequ	ence of):								
cate be executed physician and s the burial-transit	edical		•	d										
artificat ding ph e as th	/Mec	IF FEMALE:		23c. If yes, outco	me of progner	001								
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 🔲 Live Bir	th 2 ☐ Fetal ntat time of d	I death 3	Ectopic pregna					23d. Date of do Month	elivery Da	y Year
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ne Hospit n 24 hour ne Funers pleted fille	Medical	(Check 2		nysician: To the besi miner: On the basis urse Practioner: To	of examination	and/or inve	stigation, in my op	inion, death	occurred at	th e time, d ate ai	nd place,	, and due to the	cause(
To t with To t		29b, Signature and	title of certifier	J.	MD.		29c. Lice D219	nse number 44				te signed <i>(Mont</i> 15/201		Year)
5+IUA		30. Name and addre		completed cause of			Print) Y AVE.	#204	. FRI	EDERTC	K 1	MD 217	'02	
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Registra	ir T		1107 2	1 200	all Google Later Section 34 and	19.	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#20b1 TCHD, TLS, 11/10/2010 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 52010 **Physician** 0310 M Blakely November Ernest Pinckens /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner at Easton Eastor Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□F Months 01-07-1933 Maryland 214-28-1291 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

In the stath and Mental Hygiene.

In the stath and state of ther than "natural", or items 23a or 28a-f show mark if item or 21s marked other than "natural", or items 23a or 28a-f show yor or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Md. Caroline Federalsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3443 Laurel Grove Road 21632 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Caroline County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Teacher / Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zelda Johnson 2 Mckinley Pinckens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21632 Pinckens/wife Cora Mae 3443 Laurel Grove Rd., Federalsburg, Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-15-10 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Hurlock, Maryland 4 ☐ Denation 5 ☐ Other (Specify) Md. Veterans Cem. 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Bennie Smith Funeral Home 516 S.Main St., Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 11/1/2 'our Sequentially list conditions, if any, leading to infine dist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due take as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed SOIVA use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Waknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No after death.

Director: After this certific 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 3□ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death or Attending (Month, Day Year) Injury Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sic ovember 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

DHMH 17 Rev 1/2001

Dr. Dennis DeShields, 219 S. Washington St., Easton, Md. 21601

			1 - For Registrar	State of Maryla			of Health of Deat			giene		38347
			Decedent's Name (First, Middle, Last,)					2. Date of Dea		V	3. Time of Death
	Physici /Medio		Walter Gaston	Purnell					Month 11 6	5 Day	2010	2240p M
į.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Location	on of Death		4c.	County of Death	
			102 Mason Stre				Hill				rceste	
Р	Funeral		5. Social Security Number 6. Se	VM 200	i. last birthday) Yrs.	If Under 1	Days Hour	der 24 Hrs. s Min.	8. Date of Birtl (Month, Day	, Year)	Coul	place (State or Foreign ntry)
	Director		214-32-1265 Usual Residence of Decedent	75	113.				11-7-	-193	Y MD	
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					1	10d. Inside City Limits
	Mar.	tor	MD Worcest	er Sno	w Hil	1						Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip (Code			10g. Citi:	zen of What Cour	ntry?
	23a		102 Mason Stre	et		2186	3		u	ISA		
	teme teme	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decede If Yes, speci	ent of Hispanic of fy Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)		 Race - Americ Black, White, 	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2	ĭXNo Speci	ity:			^{Sp} B'Yack	
윽	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or lteme 23a or 28a-f ehow event, the Modical Exacilizar main by notified at		15. Decedent's Edu		16a, Dece	dent's Usual	Occupation				nd of Business/In	dustry
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p	ould be filed v Mental Hygie arked other t	Bec	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle,	Maiden	Sumame)	
yla	should be and Mental marked o	2	Martin Dale Pu	rnell			Mak	ole N	elson			
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (T)			_				-	r Town, State, Zip	Code)
e)	1 and Health Im 27 ther t		Mary A. Purnel		102 Place of Dispo				Hill,		21863 cation - City or To	State
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked eny Injury or other traumatic ex		Marial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crei	matory or oth	her place)	1			•	
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	3		23a. Part1. Enter the disease, or compl	ications that caused the dea							D 2100	Approximate
4	Physician		shock, or heart failure. List only or transdiate Cause (Final	ne cause on each line.	s - 1.		Comme	2.1				Interval Between Onset and Death
N.	/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):		June					
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8760,	eath certilicate be executed attending physicien and for use as the burial-transit	Physician/Medical		J								
9 X	death certific e attending p id for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregr	nancy							
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 Fel 4 Pregnant at time of	tal death 3	Ectopic pre				2	23d. Date of delive Month	ery Day Year
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<u> E</u>		Bec	25. Was case referred to medical examiner?				26. Pla	ace of Death	Check only or		12.00	2010
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ū	ding Phy h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		lc. Injury at Work?	-	28d. Describe h	iow injury	y occurred	
<u>s</u> .	Attending r death. sctor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2					
Division	or Attenester deat Director: in by the	Certification:	4 Homicide determined	28e. Ptace of Injury - At I building, etc. (Spec	nome, farm, sti cify)	eet, factory,	office		28f. Location (S City or Tow	n, State)	d Number or Rure)	al Roule Number,
_	To the Hospitel or Attentwithin 24 hours efter deatl To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phys	sicien: To the best of my kr	nowledge deat	h occurred a	t the time date	and place	and due to the	cause(s)	and manner as s	tated
	e Ho: 24 h e Fur letely	edical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	ation and/or in	vestigation,	in my opinion, o	death occurr	ed at the time, o	date and	place, and due to	o the cause(s)
	To the lawithin 2 To the Complete	Me	29b. Signature and title of contifier			29c.	License numbe	er .	- 2	29d. Date	e signed (Month,	Dey, Year)
•	2) (com	SARAD BY	AR AL	GM	0 544	22			11-9-8	2010
	201		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,	Print)	A	1	۸. ۵			
	Da		1604- Market	- St., P.	o com	oke		ri)	218	5		
\$ A	Sta Registr		31. Date filed Worth, Day, Year)	32. Registrar's Sign	ature .	Russ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Clifton Patterson 2010 November 8:20 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury 8220 Robin Hood Drive Wicomico 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 № M 2 🗆 F Months **Director** 289-28-4120 82 08/20/1928 Yrs Ohio Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with Funeral 8220 Robin Hood Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No If Yes, Give AirForce Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. veterinarian veterinary medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Elizabeth Southwick James Edgar Patterson 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8220 Robin Hood Dr., Salisbury, MD 21804 Barbara S. Patterson/spouse 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Raymond Cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/18/2010 Raymond, OH 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Le 240113000 Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ETIVEFTICUS disease or condition resulting in death) STATUS MON Medical Examiner EREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit YNS that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed : After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A Accident
Suicide Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Sompleted filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 = 2010

32 Registrar's Signature

31. Date filed (Month, Day, Year)

NUV

DOO29/68

5-DIVISION 57.

10-08876

amended item number 22/wchd/11-23-2010/map

Please	Type or F	rint in	Black I	ndelible	ink.	Ensure	All Co	pies /	Are
	State of	Marylan	id / Den	artment	of He	alth and	Menta	I Hygi	ene

Modern Name Pix, Marie J. Mari	Thomas Phillips	Pre		State of Maryla	and / Depa	artment	of Heal	th and		Hygiene	2010	38349
Thomas	Physicia	an/	Registrar 1. Decedent's Name (First, Mid	idle,Last)		rincate	Of Deal			2. Date of Dea	ath	000.0
ASIS Taylor Road ASIS Taylor Road Social S	Medical Exami	ner	Thomas Phill	ips Pres	by						Day Year r 19, 2010	1037 hrs
2. Secarity Number 2. Sec. 2. Age (in yr. last bringly) 1. Sec. 1.			4a. Facility Name (if not institu	tion, give street and nu	ımber)				ocation of Dea	th		th
The state of the	Funeral			6. Sex	7. Age (In yrs.	last birthday			If Under 24H	rs. 8. Date of Bi		irthplace (State or
The property of the property				1XM 2F			Month			in.	Fore	ign
Section of Wheel County The Part The P			Usual Residence of Decedent						<u> </u>	HDITI	20,1952	D.C.
1			10a. State 10b. Count	у	10c. City	, Town or Lo	cation					1
1	yland r-f sho	tor		ester	S	now H		Code			On Citizen of What Co	
Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	or 28:	jrec		n 3							log. Citizen di what Co	anti y r
Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	with d	lal		12. Was Dec	edent Ever in U	.s. 13.	Was Decede	ent of Hispa	anic Origin? (\$	Specify Yes or No	U S 14. Race - Ame	
Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	death or iten must b	in		1 Yes	2 No		If Yes, specif	fy Cuban, N	Mexican, Puerl	to Rican, etc.)	White, etc.	
Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	safter ral", o			Lor Dates:								
Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	2 hour					16a. Dece	dent's Usual g most of wor	Occupation rking life. D	O NOT use re	etired)		
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Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	e, N l and l Health item i	ı	20a. Method of Disposition		20b.	Place of Dis	position (Nan	ne of ceme	etery,	Date A1	20c. Location - City o	r Town, State
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Physician (Medical Examiner) 238. Part Librar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate principle Approx	altil mit. ppartm	ľ	21. Signature of Funeral Service	e Licensee		22	2. Name and	Address of	Facility 91	7 W. I	sabella Ş	treet
The control of the co		_	Ussell	John	14-1-1	В	ennie	Smi	th Fu	neral H	Home, Salb	ury, MD
Sequentially St confidence Part				e on each line.			er the mode o	of dying, su	ich as cardiac	or respiratory arm	est, shock, or heart	Between Onset and
The state of the s	Examiner		Immediate Cause (Final diseas or condition resulting in death)									Death
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Spood of the first of the control of	3876 rtificat ling ph as the	an/N	3b. Was decedent pregnant in	the 1 Live bi	irth	2	Fetal death	3 🗌	Ectopic pregn	ancy		
Spood of the first of the control of	OX 6	sick		thousand I		ath 5	Other (Spec	cify)		-		
Spood of the first of the control of	D. B triffe d by the	됩	Part II. Other significant cond			esulting in th	e underlying	cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
24a. Was an autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 25c. Was case referred to medical examiner? 1	P.C.									1 Yes	2 No 3 Pro	bably 4 Unknown
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filled (Month, Pay, Year) 2010 32 Registrar's Signature	rds requi	ete										
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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 31. Date filled (Month, Pay, Year) 32. Registrar's Signature	nding ading th.	ü	1 X Notusal	(Month,	of Injury Day,Year)	28b. I≀me o	of Injury 2			28d. Describe r	now injury occurred	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 31. Date filled (Month, Pay, Year) 32. Registrar's Signature	isio Atter er deal rector t by th	icat	2 Accident Inve	estigation 28e Place	of Injury - At ho	ome, farm, st	reet, factory.			28f. Location (S	Street and Number or Ru	ural Route Number, City
29d. Date signed (Month, Day, Year) November 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 29d. Date signed (Month, Day, Year) November 20, 2010	Div ital or urs aft	erti	dete	lid not be	. ,		,		3.			, ,
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29d. Date signed (Month, Day, Year) O.C.M.E. November 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) O.C.M.E. November 20, 2010	To the within To the Compl	ed j	2 🖳	and manner st		nd/or investi				at the time, date		
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Pay, Year) 2010 32. Registrar's Signature		≥	Signature and title of certifi	er // .			29c.					
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Pay, Year) 2010 32. Registrar's Signature 4			30 Name and address of account	me Shel	of death (Ha-	239)		J.U.IVI.I	L .		NOVERTIDE ZU, Z	
State 31. Date filed (Month, Day, Year) 2010 32. Registrar's Signature				According to the contract of t	141.00	,	Penn Stre	eet, Balti	imore, MD	21201		
Registrar NUV 4.3 2010 Lenux D. Sparre			31. Date filed (Month, Day, Year,		gistrar's Signatu		arkel					

Christopher Gu	istav		nent of <i>cate of</i>		Mental H		20 leg. No.	0 3835
Physic		Decedent's Name (First, Middle,Last)				2. Date of Dea	th	3. Time of Death
Medical Exam	iinei	Christopher Gustavo Rosales 4a. Facility Name (if not institution, give street and number)		h City Town and an	ation of Dooth		Day Year r 14, 2010	0153 hrs
. /		4500 Jones Mill Road	"	b. City, Town, or Loca Bethesda	ation of Death		Montgome:	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)		f Under 24Hrs	. 8. Date of Bir	th(MM/DD/YYYY) 9.	
Director		218-17-1182 ₁ M _{M 2} F	29 _{Yrs.}	Months Days	Hours Min.	Aug 1	4 1981	reign Country) D . C .
ķ	1	Usual Residence of Decedent 10a. State 10b. County 110c. City. Tow						
		,						10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show any d at once.	cto	MD Montgomery Wh 10e. Street and Number	eato	n 10f. Zip Code		11	0g. Citizen of What 0	
the Ma t or 28	ral Director	 11610 Georgia Avenue		20902			USA	ountry:
with ms 23,5	Fra	11 Marital Status		Decedent of Hispani			- 14. Race - Ar	nerican Indian, Black,
r death or ite	Funer	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		s, specify Cuban, Me			White, etc	
rs afte ural", miner	ģ	3 Wildowed 4 Divorced in res, Give rear or Dates:		Yes 2 No <i>sp</i> s Usual Occupation (vadori		
72 hou 1 "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		st of working life. DO			16b. Kind of Busine	ss/industry
036 nithin ane.	d E		inan	cial Man	ager		Auto S	Sales
15-0 filed v I Hygid d othe	ပ္ပိ	17. Father's Name (First, Middle, Last)					Maiden Surname)	longia
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Miguel Angel Rosales 19a. Informant's Name/Relationship (Type, Print) - Father 1	h Mailing		_		tella Va	
∪ 8 5 5 2 €	_		1610	Georgia	Ave.	, Whea	ton, MD	20902
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 20b. Place 1 Burial 2 Cremation 3 Removal from State Pacers	of Disposit	on (Name of cemeter	ry. No	Date V · 19	20c. Location - City	or Town, State
imo Page nent o lant:		4 Donation 5 Other Specify:	Par		1	010	Rockvil	le,MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	22, Na F r	me and Address of F	acility o 1 1	ins Fu	neral Ho	me Inc. er Spring, M
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do r						Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a.Multiple Injuries		, ,		,	,	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):						
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
cuted nd fransit	Exa	events resulting in death) Last Due to (or as a consequence of):						
50, te be executed ysician and	edical	UNPENDED AMENDED						
3876 rtificate ing phy as the t	n/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy		I death 3 Ed	ctopic pregnar	ncv.	23d. Date of deliv	ery Day Year
Box 6876 e death certificate the attending phy ed for use as the	sicia	past 12 months? 4 Pregnant at time of death		r (Specify)	otopio prograd		l worth	Day Tour
D. Be t the de by the	Physician/M	Part II. Other significant conditions contributing to death but not resulting	a in the un	tertying cause given	in Part I	23e Did to	acco use contribute	to the cause of death?
ires that the signed by I be detach	ò		9 111 1110 4111	zorrymy dauge grven	mi an.			robably 4 Unknown
ords, w requir ts been s should I	letec					24a. Was a		autopsy findings available
eco he law ate has	Completed					autops perform 1 Yes 2	med? death	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical	-	26.Place of De	eath (Check or			165 2 140
'hysici	입	19 163 2 110	utpatient	1	4 Nursing	Home 5 F	Residence 6 🗸 Ott	ner: Scene
Division of Vital Records, P.O. Box 6876i or the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	ü	(Month Day Year)	Time of Inju Ohrs	ıry 28c. Injury at V	r		ow injury occurred uto collision	
ivision or Attene after death Director: I in by the	icat	2 Accident Investigation 28e Place of Injury - At home f	arm, street.			28f. Location (S	treet and Number or	Rural Route Number, City
Division pital or Attene ours after death teral Directors	Certification:	4 Homicide determined (Specify) Major Road / H		,,	4	or Town, St 500 Jones Mi	ate) lls Road, Bethesda	a, Md.
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, de			d place, and d	lue to the cause	(s) and manner as st	ated.
To th To th Comp	Medical	one) 2 Medical Examiner:On the basis of examination and/or i and manner stated. 29b. Signature and title of certifier	nvestigatio			the time, date a		
5		A a Ch		29c. License num O.C.M.E.			29d. Date signed (A November 14,	
	-	30. Name and address of person who completed cause of death (Item 23a)						
		Margarita Korell MD. Assistant Medical Examiner		n Street, Baltim	nore, MD 2	1201		
St Regist		31. Date filed (Month, Day Year) 32 Registrar's Signature	park	1				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea 4:00a Physician/ Rinaldi Now. 11, 2010 Year Slonina Leontyna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Mt. Airy Examiner Montgomery 9226 Brown Church Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖽 F Months Days Min. 001-14-6505 Hours. 197224 1922 N.H. 88 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. Counts 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director MD Montgomery Mt.Airy 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9226 Brown Church Road 21771 USA 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Engraver Be permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked oft
any injury or other transmission. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Stanley Slonina Catherine Suroweicj 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Thomas S.Rinaldi/Son 9226 Brown Church Road Mt.Airy, Md. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Gate of Heaven 11/16/201d Silver Spring, Md 4 Donation 5 Other (Specify) PHIME ADERINALDI FUNERAL SERVICE, P.A. 21. Signatur 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Acute stroke mo. Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease of linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by critical aortic stenosis 1 \square Yes 2 \square No 3 \square Probably 4 \bigstar Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes _ 2 🔀 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 Yes 2 No M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43202 Nov. 15, 2010 30. Name and address of person who sompleted cause of death (Item 23a) (Type, Print) Blankfard M.D. 3305 N.Leisure World Blvd.Silver Spring, Md Charlene 31. Date filed (Month, Day, Year) Registrar's Signam State NOV 16 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 Physician/ Month MARIANNE RIDENOUR November Δ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 28, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min Director 220-28-2856 87 Germany Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Frederick Thurmont ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7518 Franklinville Road 21788 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ※ No 5 Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan any injury or other traumatic event, the Medical Exan If Yes, Give Year or Dates White Completed 3 XXWidowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Facto</u>ry Worker Shoe Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karl Johann Seitz Wilhelmina Baum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7518 Franklinville Rd., Thurmont, MD 21788 Joseph Ridenour / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 2010 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory Frederick, Maryland al Service Licensee 22 Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Prebrovascu Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and use as the burial-trar resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dr PSSUME 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 No 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 📈 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatu D51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year, 32. Registy r's Signature State Registrar Marina.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TITEM#19a, perFH, G910, 12/9/2010, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alma Beard Rippeon November 2010 7:30 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heartfields Assisted Living Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day
April 24 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1915 Maryland 212-03-3079 95 Director Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 1820 Latham Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3x x Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own home other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Beard Mary Lare 19a. Informant's Name/Relationship (Type, Print) Austin Rippeon, Jr./ Austin Ribbeon — een 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6726 S. Clifton Road, Frederick, Maryland 20b. Place of Disposition (Name of cemetary, crematory or other place) Union Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11-13-2010 4 ☐ Donation 5 ☐ Other (Specify) Libertytown, Maryland 21. Signa of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Demention Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Breast Cancer 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living hours after death.

neral Director: After this or filled in by the funeral dire 1 🗌 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the only one 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) Hiren mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) mo 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 11 2010 Ray Homer Ridder Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 955 Mason School Road 0akland Garrett If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) 8. Date of Birth 1 🗶 M 2 🗆 F Months Days Hours Director 215-36-7863 92 1918 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 955 Mason School Road 21550 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) dairy farmer farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ernest R. Ridder Sarah D. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Ridder-son 72 Box 89-A, New Creek, WV 26743 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) cemetery, crematory or other place) 12/2/2010 Johns Cemeterv Oakland, MD 21. Signature Funeral Service Licerises 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. N. 2nd St Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery • Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Year g Unknown 9 Unknown director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Tp the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1) cJ33

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2010

82. Registrar's Signature

Thomas G. Johnson, MD, 311 North 4th Street, Suite #2, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State		State	of Mar	ryland /						lental Hy	giene			A A A 74 194
			Registrar 1. Decedent's Name	(First Middle I	ast)			Cer	tificate	OT L	eatn		2. Date of De	Reg. No.			38355
	Physicia												Month	Pay	,	Year	3. Time of Death
	Medio Examir		Kenneth E 4a. Facility Name (if n	ot institution, g	ve street and nu	mber)			4b. City, 7	Town or	Location	of Death	1.6	100	ounty o	f Dogth	10:15 AM
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	Funeral Director		5. Social Security Num 218–64–77	83	Sex 1 🛣 M 2 □ F	7. Age (/	In yrs. last bii	Yrs.	If Under Months	Days	If Unde Hours	Min.	8. Date of Bir (Month, Da July 8	av, Year)		9. Birthpla Country Mary	
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the	or 2	قَا	10e. Street and Numb	per					10f. Zip	Code		_		10g. Citize	en of Wi	hat Countr	v?
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baltimore,	Department of Healtl Important: If item 2' any injury or other tonce.		1 🔀 Burial 2 🗌 4 🗆 Donation 5	Cremation 3		State		ry, crem	atory or oth	er place			1, 201			ity or Town	
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The law re	r this certificate has be rral director, page 2 sh	Completed											24a. Was autop perfo 1 Yes	rmed?	prid dea	re autopsy or to comp ath? Yes 2	findings available letion of cause of
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Physi	this cal dire	욘	1 Yes 2 7	Vo			2 ER/OL				_ 4 ∟ N	ursing Hon	ne 5 🗆 Resid	ence 6 🗌	Other (Specify)	
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To t	To t		29b. Signature and title			71			29c. L	icense n	number			29d. Date si	gned (/\	fonth, Day	; Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Carroll Douglas Reams 8:58 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6778 Oakland Sang Run Road 0akland Garrett 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Country) MD Director 219-56-7682 58 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Garrett 0akland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6778 Oakland Sang Run Road 21550 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Black, White, etc. Armed Forces 9 Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) construction electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Ross Reams Nina Louise Reams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina L Reams-mother Oakland Sang Run Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Taylor Sines 11/21/2010 4 Donation 5 Other (Specify) Oakland, MD 21. Signature @Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home P. N. 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ CONTACT QUISHOT Wound to hea disease or condition resulting in death) SEL N DS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or sels consequence or) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) Dav Year 1 Yes 2 No 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Date of injury (Month, Day, 28b. Time of Certificate: 28d. Describe how injury occurred
Selfin Flided guns lot 28c. Injury at 1 🔲 Natural work? 5 Pending Investigation 8:58 AM Accident 10 3. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, GALLAND WD 3125 78 OACHANDSANGRUNCO. Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

2 2 2010

of death (Item 23a)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lillian G. Richardson 2000 Medical lovember 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitationa Nursing Ctr Wicomico **Funeral** If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Months Days 4-19-191 Hours Min. **Director** 213-14-7002 Mary Land 99 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7304 Truitt Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decouder Armed Forces?

1 ☐ Yes 2 🗓 No 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Own Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Linwood Richardson Grace Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9554 Millard Long Road, Westover, Maryland 21871 <u> Janet Boston - Daughter</u> 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-17-2010 Dennis Cemetery Willards, Maryland e of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Þ 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Inset and Death cas disease or condition and cer Medical resulting in death) Due to (or as a consequence of): Examiner ern Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Pa1. Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 \(\subseteq \text{No.} \) 1 Tes in 24 hours after death.

The Funeral Director: After this certificant pleted filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 🗆 Yes 2 🗀 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) CEC

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NUV

15

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended item#19a, WCHD, SLU, 11.18 entiticate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:45PM Barbara Ann Roberson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** MICO Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 1 194] **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Virginia 69 Director 215-38-2167 Jan. Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or Funeral 7887 Jersey Road 21801 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Examiner Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Assisted Living Sarah Margaret & Molly's Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Certified Nursing Assistant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martha Elizabeth Robertson Harry H. Chandler BARBARA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190 drigmant's Name/Relationship Type Hijnt band 27 Charles Roberson/ Husband Department of Health Important: If item 27 any injury or other tr 7887 Jersey Road - Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/22/2010 Eastern Shore Veteran's Hurlock, Maryland . Signature of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland 10101 Jolley Memorial Chapel 1213 Jersey Road 21801 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ MULTIPE MYRIOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗆 Yes HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After Natural 5 Pending work 1 Yes 2 No Investigation Could not be Accident filled in by the Suicide 3 ☐ Suiciae
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours as To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. соmpleted (Check Çértifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

6 HWAW
31. Date filed (Month.)

32/Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at	
permit. Pages 1 a	Department of He	Important: If item	any injury or othe	once.

Baltimore, Maryland 21215-0036

Physic /Med Exam

Funera

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	for State Of Williams State Of	•	Certificate of D		Reg. I	71111	38359			
1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death			
ian	Stanley E. Reedy				November 1		2:10 p M			
ical	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or t			4c. County of Death				
iner	Homestead Manor, 410 Color		Denton Caroline							
		ge (In yrs. last birth		If Under 24 Hrs.	8 Date of Birth	9. Birth	nplace (State or Foreign			
	216-28-6260 1 ¹ → 2□F	Months Days Hours Min. (Month, Day, Year) Country) Oct. 16,1932 Laurel, MD								
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L									
ğ	MD Caroline	Denton					1 □Yes 2 🙀 No			
9	10e. Street and Number	Benton	10f. Zip Code			Citizen of What Cou	untry?			
Funeral Director	410 Colonial Drive		21629			A				
Je l	11. Marital Status 12. Was Decedent Armed Forces		ver in U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu			14. Race - Amer Black, White				
oy Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates:	No	1 DVas 2 DNo Specific			Specify: White				
Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines				ndustry			
mple	Elementary/Secondary (0-12) College (1-4or	5+)			S. a. a. a. a. a. a. a. a. a. a. a. a. a.					
ြပိ	O Falls & New (First Middle Least)	Se	curity Offic		(First, Middle, Maid	ecurity				
	17. Father's Name (First, Middle, Last)					en Sumame)				
ျ	Wilbur Murl Reedy			Bertha Ma						
	19a. Informant's Name/Relationship (Type. Print)	i	Mailing Address (Street a.							
	Donna Ksenich		021 Greensbo							
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of cemetery	Disposition (Name of , crematory or other place) :	Date 20c.	Location - City or	lown, State			
	4 □ Donation 5 □ Other (Specify)	Eastern	n Shore Vet							
2	21. Signature of Funeral Service Licensee		22. Name and Address	s of Facility PO	Box 160,	Greensbo	ro, MD 21639			
Ŕ	1 Sem (the		Fleegle &			L Home, P.				
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do n line.	ot enter the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between			
	Immediate Cause (Final disease or condition	mm	C				Onset and Death			
	resulting in death) Due to (or as a consequence of):									
, i	Sequentially list conditions, b.									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury tresulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
Exar	that initiated events c	s a consequence o	f):							
	C _d									
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N	IF FEMALE: 23c. If yes, outcom	e of pregnancy	0.00			23d. Date of del	ivery			
by Physician/	in the past 12 months?	2 Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year			
Phy	9 Unknown		the underlying cause give	n in Part I	23e Did tohace	co use contribute to	the cause of death?			
d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of t									
Completed					24a. Was an	24b. Were au	topsy findings available			
lmo	24a. Was an autopsy findings availat autopsy prior to completion of cause of performed? defined the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of the c									
BeC	25. Was case referred to medical examiner?									
27. Manper of Death 27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?										
catio	2 ☐ Accident investigation		M 1 □ Y rm, street, factory, office	res 2 □No						
Certification: To	t and Number or Ru tate)	ıral Route Number,								
	29a. Certifier (Check only 2 Medical Examiner: On the basis	se(s) and manner a	s stated.							
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Moc										
mo D0023522 11/16/9011										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Butter 136 Lednum Are Preston MD 21655									
	130. Name and address of person who completed cause of	Le Le d	Inum Ava	Pres	ton N	ND a	1655			
tate	1	strar's Signature	,							
trar	MOV 1 7 2010	un A	Back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LUCY JUNE RAEMSCH NOV.30,2010 8:15P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MD. HOSP. CENTER PRINCE GEORGES CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign VACountry) **Funeral** 8. Date of Birth Days 1 □ M 2**X** F Hours 234-70-1370 5Month 6Pav 1 1914 6 64 **Director** Yrs Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. PRINCE GEORGES BRANDYWINE 28a-f 1 🗆 Yes 2 🖁 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10505 CEDARVILLE ROAD U.S.A. 20613 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 9 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL CLERK RETAIL STORES other i <u> 12th</u> Be 17. Father's Name (First, Middle, Last) ge 1 and 2 should be filed it of Health and Mental Hi : If item 27 is marked oth or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) CLIFTON LEE TEETS, SR. GOLDA VIRGINIA STRAWDERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RODNEY D.GAY, JR.-SON 11315 CEDARVILLE ROAD BRANDYWINE, MD. 20a. Method of Disposition

1
Burial 2
Cremation 3
Removal from State TROPOLITAN CREMATORY 20c. Location - City or Town, State . Page 1 Department of Important: If it any injury or o 12-6-1 QALEX., VA. M00479 21. Signature of Sameral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocamia 91c Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): by the attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Dianeter Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo 1 🗌 Yes Other: 1 Inpatient 2 KER/Outpatient 3 I DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: 24 hours To the within 2

> State Registrar

29a. Certifier

2 | | 3 | |

29b. Signature and title of certifier

831 University Blvd.#27 Silver Spring,Md 20903 Tahmina K.Ahmed M.D. 31. Date filed (Month, Day, Year)

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00060100

29d. Date signed (Month, Day, Year)

November 15,2010

			For State	ate of Maryland				ınd Mental I	-lygier	ne l	38362
			Registrar		Cen	ificate of D	Death		Reg.	No.	00004
	Physicia	an/	1. Decedent's Name (First, Middle, Last) David Sacks					2. Date o	f Death	Day Year	3. Time of Death
	Medi	cal	An English Name (Kent in the time)							9, 2010	
	Examir	ner	4a. Facility Name (if not institution, give street 15310 Pine Orchard I		ਸ	4b. City, Town, or Silve				4c. County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year			Rinth		irthplace (State or Foreign
	Director		051-14-6780 1x M	2 □ F 92	Yrs.	Months Days	Hours	Min. (Month	Birth Day Yea 16, 1	017	New York
== 8	, Ma		Usual Residence of Decedent					NOV.	109 1		New TOTK
	yland f sho	흕	10a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Mar 28a- otifie	ire	MD Montgomery	Si1	ver S	Spring					¥☐ Yes 2 ☐ No
	th the	ョ	10e. Street and Number			10f. Zip Code			10g.	Citizen of What (Country?
(15	ms 2 mus	Funeral Director	15310 Pine Orchard I			209				U	SA
·^	or ite	Ę	Ar	as Decedent Ever in U.S. med Forces? See 2 No	13. W	as Decedent of His Yes, specify Cubar	spanic Origi n, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Wh	
ဗ္ဗ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 to Widowad 4 Diversal	Yes, Give par or Dates.	1	☐ Yes 2 🛣 No	Specify:			Specify:	White
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2	iin 72 ie. han " e Mei	Ĕ	(Specify only highest grade con Elementary/Seconday (0-12) Co	ollege (1-4 or 5+)	(Give ki life. DO	nd of work done do NOT use retired)	uring most o	of working			,
7	y with ygier her t	BeC		5+	Econo	mist	_			Econom	ics
and	be filed vertiled by the lental Hygriked other ic event,	PB PB	17. Father's Name (First, Middle, Last)					's Name (First, Mid		en Surname)	
ž	should be filed within 7 n and Mental Hygiene. 7 is marked other than raumatic event, the Me	-	Isadore Sacks					ophie Tu			
Maryland 21215-0036	12 sho Ilth an 27 is i		19a. Informant's Name/Relationship (Type, Pri. Michael Sacks/Son	nt) 19				or Rural Route Nur			Zip Code) y1and 20145
Ġ,	and Heal tem 2		20a. Method of Disposition	20h Place		tion (Name of	UCEA		_		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 🗆 Cremation 3 🗆 Remo	val from State ceme	tery, crema	itory`or other place		Date	- 1	Location - City o	
≣	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Jude		em. Grds.		11/11/20			aryland rection, Inc
ñ	permit Depar Impor any in		NACC - 20101 7	M01597							yland 20852
			23a. Part 1. Enter the disease, or complication	ns that caused the death. Do							Approximate
	-nysician/		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition Ath	e on each line. Leroscleratic	Car	diovascu	lar D	isease			Interval Between Onset and Death Years
	Medical Examiner		resulting in death) a. —	Due to (or as a consequence							20000
	Lxammer	<u>.</u>	Sequentially list conditions, b. —								
	D #D	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence	e of):						
	icate be executed g physician and is the burial-transit	Exal	that initiated events c. —	Due to (or as a consequence	e of):						
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09/	cate phys the		d								
8	certificate nding physuse as the	/N		ves, outcome of pregnancy						23d. Date of de	alivany
Rox	v requires that the death certific is been signed by the attending I should be detached for use as	Physician/M	1 Yes 2 No 4	Live Birth 2 Fetal dea Pregnant at time of death		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
o.	the c by the tache	hys	9 Li Unknown	Unknown							
<u>7.</u>	The law requires that the ate has been signed by the page 2 should be detach	by F	Part II. Other significant conditions contribution	ing to death but not resulting	g in the und	derlying cause give	n in Part I.	23e. D	d tobacco	use contribute t	o the cause of death?
ds,	quire en siç ould b	ted						1	☐ Yes	2 🕱 No 3 🗆 F	Probably 4 🗆 Unknown
Vital Kecords,	aw re as be 2 sh	Completed						24a. W	as an	24b. Were a	utopsy findings available completion of cause of
Y Y	The l	9							erformed?	death?	s 2 🗆 No
Į.	cian: ertific ector,	Be	25. Was case referred to medical examiner?	1.				(Check only one)			
=	Physi this c al dire	욘	1 ☐ Yes 2 ☒ No Hospita 27. Manner of Death 28.	1 Inpatient 2 I ER/C	<u> </u>		4 ∐ Nurs	ing Home 5 R	esidence	6 Other (Spe	cify)
0	ding I h. After funer	Certificate:	1X Natural 5 ☐ Pending	a. Date of injury (Month, Day, Year) 28b.	Time of injury	28c. Injury a work?		28d. Describ	e how inju	ury occurred	
<u> </u>	deatl deatl ctor: y the	ij	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	. Place of Injury - At home, f	farm etroo		es 2□N		- 104	111 / 5	75 7 7 7 7
DIVISION OF	after after		4 Homicide determined	building, etc. (Specify)	iai III, 31.00	i, ractory, office			Town, Stat		ural Route Number,
_	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying Physician: 1	o the best of my knowledge	, death oc	cured at the time, o	date and pla	ace, and due to the	cause(s)	and manner as st	ated.
	the Hi nin 24 he Fi hplete	Mec	(Check 2 L Medical Examiner: On	the pasis of examination and tioner: To the best of my know	or investia/	ation. In my opinion.	. death occu	irred at the time, da	e and plac	e, and due to the	cause(s) and manner stated
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	20		Jeram K	Mumi,		1	D0838	1	No	vember 1	.0, 2010
			30. Name and address of person who complete)1nc 1/-	mr. 1 -	nd 2002	2
			Dr. Avrunin, Benjami 31. Date filed (Month, Day, Year)	n, 18111 Pri	nce P	nilip Dr	rve, (Jiney, Ma	гута	nd 2083	0.4
	Stat Registra	٠	NOV 16 2010	. riegistrar s olgrianie	par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** November 2010 /Medical 4a. Facility Name (If not institution give street and number) Town, or Location of Death 4c. County of Death **Examiner** Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🛱 F Yrs Director 217-28-4372 MD Usual Residence of Decedent 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, 11s, Modeal Examina mass be mutilled at 1 ☐ Yes 2 ▼ No Director MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22129 Reeses Corner Rd. 21661 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 [] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olan David Simpkins Martha B. Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Joyce Rogers/Niece 103 Patton Way Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State 4☐Donation 5☐Other (Specify) Chester Cemetery 11-14-2010 | Chestertown, MD Ineral Service Licen 21. Signature 22. Name and Address of Eacility Fellows, Helfenbein & Newnam Funeral Home Jan 130 Speer Rd. Chestertown, MD 21620 llows 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as each of the control of the con Examine law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical use as the IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 mor 1 Yes 2 No 9 Unknown Yea Dav 5 Other (specify) Ö been signed by the should be detached σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t 24a. Was an autopsy or Attending Physician: The perforn Cansfusion certificate Division of Vital 1 ☐ Yes director 25. Was case referred to medi examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Vatural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

5

State Registrar son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Swanhart November 15, 2010 Physician/ Matthew Medical 4a. Facility Name (if not institution, give street and number) 7060 Basswood Road 4b. City, Town, or Location of Death Frederick Examiner 4c. County of Death Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 5. Social Security Number 210-28-8680 Feb. 5, 1937 1 ☒ M 2 ☐ F Pennsylvania **Director** 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Exa⊓iner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 10f. Zip Code 21703 10e. Street and Number 10g. Citizen of What Country? 7060 Basswood Road USA permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 \boxtimes Yes 2 \square No If Yes, Give Year or Dates. 1955–57 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 White 1 Yes 2 K No Specify Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Gordon Swanhart Mildred Conrad 19a. Informant's Name/Relationship (Type, Print) Victoria Swanhart/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7060 Basswood Road, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Monica Cemetery November Chest Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) 19, 2010 21. Signature of Fun 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Obstructive Pulmonay Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a 1 Yes 2 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) Other: 1 Yes 2**X** No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending after death. Director: Aft 2 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the l 29c. License number 0 0 0 6 222 3 29d. Date signed (Month, Day, Year) November 15, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print).

PLENFACE, MP 2170 2. TJ DAIVE,

6:00A. M

1 Yes 2 X No

Approximate Interval Between

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Physicia	n/	1. Decedent's Name (First, Middle									2. Date of Do Month		ay_	Year	3. Time of Death
Medic Examin		Laura 4a. Facility Name (if not institution		mber)			4b. City,	Town, or	Location of	of Death	Novemb		c. County		10:09A M
		11550 Windson					I	jams	svill	e			-	deric	k
Funeral Director		5. Social Security Number 216-54-8387	6. Sex 1 ☐ M 2 🔀 F	7. Age	99	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D June	rth ay, Year)	911	9. Birthpi Count Mar	ace (State or Foreign
and show l at	or	Usual Residence of Decedent 10a. State 10b. County	,		10c. City,	, Town or Loc	ation							10	d. Inside City Limits
Maryli 28a-f	irect		erick			Ijams	ville	!							1 🗆 Yes 2 😾 No
ith the	Funeral Director	10e. Street and Number 11550 Windson	r Road				10f. Zip	Code 217	754					What Count	ry?
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hours natura Jical E	lete	15. Decede	ent's Education			16a. Deced						16b.		Whi	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seconday (0-12)	est grade completed College (+)	life. DO	ind of wor NOT use memak	retired)	unng most	of worki	ing		Own 1		,
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should and Me is mar		19a. Informant's Name/Relations				19b. Mailin	g Address	(Street a	nd Numbe	er or Rura	al Route Numbe	er, City o	or Town, S	tate, Zip Co	ode) 20872
and 2 s lealth em 27 ther tra			p - Son		I and the				Park		race,				
Page 1 ant of Bint: If ite		20a. Method of Disposition 1		n State	ce	ace of Dispos metery, crem Olive	atory or ot	her place	ey N		Date 22, 201			City or Tov erick	_{vn, State} ,Maryland
permit. Departn Importa any inju		21. Signature of Fuheral Service	-	1.	10. 4) 22 M	Name and	Addres	s of Facility	, liam	ns P.A. Damas	. Fu	nera	1 Hom	e
TO = # 0	Н	23a. Part 1. Enter the disease, or	r complications that	caused	the death.								Mar		20872 Approximate
Physician/		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	ach line		otic H									Interval Between Onset and Death Years
Medical Examiner		resulting in death)	a.		conseque		earc	עדפי	case						rearb
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h certif tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1 ☐ Live		of pregnan		Ectopic p	regnancy	/				23d. Dat	e of deliver	у
ne deat / the at ched fo	Physician/Medica	1 Yes 2 XNo 9 Unknown	4 ☐ Pre		time of de	eath 5	Other (spe	ecify)			.		Moi	nth [Day Year
s that the		Part II. Other significant condition	ons contributing to	death bu	ut not resul	lting in the ur	derlying c	ause give	en in Part I		23e. Did t	obacco	use contr	ibute to the	cause of death?
equires een sig nould b	eted	Hypertension									1 🗆	Yes 2	X No	3 🗌 Proba	ably 4 🗆 Unknown
e law r e has b ge 2 sł	Completed by	Hypercholeste									24a. Was auto perfo		р		sy findings available pletion of cause of
ding Physician: The law h. Affer this certificate has funeral director, page 2	Be Co	Perifheral Va 25. Was case referred to medical	scular Di	seas	se			26. Pla	ce of Deat	h (Check	1 🗆 Yes	2 X N	lo 1	Yes 2	! □ No
hysici his ce al direc	욘	examiner? 1 Yes 2 No				R/Outpatient	3 🗆 DO	Other	r: 4 🔲 Nu	rsing Ho	me 5 🔀 Resi	dence	6 🗌 Othe	r (Specify)	
iding F th. After 1 funera	cate:	27. Manner of Death 1	9	of injur oth, Day,		28b. Time of injury	м 28	c. Injury work?	at Yes 2 🗆		28d. Describe I	how inju	ry occurre	ed	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place		ry - At hom . (Specify)	ne, farm, stre					28f. Location (S City or Tov			r or Rural F	Poute Number,
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he Hos in 24 h he Fun pleted	Medical	(Check 2 \(\sum \) Medical E	Examiner: On the ba	sis of ex	amination	and/or investi	gation, in m	y opinior	n, death oc	curred at	the time, date a	and place	e, and due	to the caus	e(s) and manner stated
Voith Voith Com		29b. Signature and title of certified			/ '	0	29c.	License.					_	(Month, Da	
	ŀ	30. Name and address of person	who completed care	se of de	attriltem 3	23a) (Tivne Pr	int)			D164	128	Nov	rembe	r 16,	2010
10		Casper E. Clin	e III, M.	D.	309	West	9th		Fred	lerio	ck, Mar	y1ar	nd		
Stat Registra	e ir	31. Date filed (Month, Day, Year)	17 20 02.	Registra	r's Signatu	re A .	par	11							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 08:40 AM November June M. Schoonover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) Days Hours Min leveland. 1 □ M 2 🗶 F Ohio Director 495-20-6892 84 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No North East Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21901 United States 92 Cliffview Drive, Chesapeake Isles within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic Elementary/Seconday (0-12) College (1-4 or 5+) Church Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Myers H. Ralph Neal 6% Mailing Address (Street and Number or Bural Route Number, Cityor Town, State, Zip Code)
North East, Maryland 21901 19a. Informant's Name/Relationship (Type, Print) Ned W. Schoonover / Spouse Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of November cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 18, 2010 Newark, Delaware 21. Signature 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. Lis only one gause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence oi). it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death g Unknown 9 Unknown t signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has To the Hospital or Attending Physician: The Is within 24 hours after ceath.

To the Funeral Director: After this certificate ha completed filled in by the funeral director: name Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certific

State Registrar

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Signature and til

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ed (Month, Day, Year) NOV 18 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 29 2010 Rebecca Stemp 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Egle Nursing & Rehab Center Allegany Lonaconing If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) C. 6, 1915 216-05-6204 1 ☐ M 2**XX** 94 Maryland Director Usual Residence of Decedent Department of Health and Mental Hygiene. Instrument, or items 23a or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Allegany Frostburg 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Maple Drive 21532 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Completed 3XXWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Retail College (1-4 or 5+) Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Machin Bertie Randall t, Page 1 and 2 should by tment of Health and Mer rant; If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Teaberry Lane, Frostburg, Maryland 21532 19a. Informant's Name/Relationship (Type, Print) Shirley Sleeman/ niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State 11/29 Date 010 1 Burial 2 X Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ yocoldial resulting in death) Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine within 24 hours after death,

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Inhetes Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ★No Pregnant at time of death
Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteomyelitis, diabetic foot yleers, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown arterial peripheral vasculer 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Dr. Thomas Devlin, 20 Douglas Ave, Lonaconing, Maryland 21539 62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

021488

Nov. 29, 2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38369 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Raymond Franklin Month Day Smith 2010 1250 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Reg. Medical Center rumberland Allegan If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace State or Foreign Funeral 1**X** M 2 □ F Days (Month, Day, Year) an 2, 1925 Months Hours Min. Maryland 213-2242626 85 Yrs. Director Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Allegany Westernport 1 Yes 2XXVn 10e Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral Stoney 21562 24428 Run Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 25 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) Paper Manufacturer College (1-4 or 5+) Paper Maker 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Loy Smith Ritchie Mary permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print)
Mary Lou Smith/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24428 Stoney Run Road, Westernport Maryland 21562 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Philos Cemetery or other 11/28/2010 Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Š K 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIM Physician/ disease or condition resulting in death) MIFET Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician use as the burial Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ idner 1 Yes 2 Wo 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performe certificate 25. Was case referred to medica examiner? **Division of Vital** To the Hospital or Attending Physician: 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) funeral 27. Manner of Beath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) PHYSICAN November Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 SFTON DRIVE CUMBARLAND MD 21502 OVERIA JR. MD 1000 Month, Day, Year) State 29 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year VIRGINIA B. SATCHELL November 6180 ,2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death albo soita aston 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 🔽 F 215-20-2069 86 SEPT. 18, 1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No TALBOT EASTON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 218 SOUTH AURORA STREET 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 WAITRESS n FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DELLA MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12383 CONNELLY ROAD, CORDOVA, MD 21625 C. RANDALL SATCHELL, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 11/5/2010 EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 SOUTH HARRISON STREET, EASTON, MD TOHN M FRCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

HARRY BOLDEN BLADES

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

or e

ral", or items 23a Examiner must b

or other traumatic

permit. Pages 1 and 2 a Department of Health a Important: If Item 27 Is any Injury or other trau

Physician /Medical

Examiner

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Directo

Funeral

2

Completed

Be

ဥ

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

20a. Method of Disposition

21. Signature of Funeral Service Licensee

Immediate Cause (Final disease or condition resulting in death)

NON CARDIOGENIC PULMONARY EDEMA Due to (or as a consequence of):

CECUM

PERFORATED Due to (or as a consequence of)

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

1 Yes 2 No 3 Probably 4 Unknown

autopsy perform

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No

26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier (Check only

29c. License number

29d. Date signed (Month, Day, Year)

Mul Betser

D0059487

11-2-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN BOTSIS

219 SOUTH WASHINGTON STREET, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year) NOV 0 4 2010

DHMH 17 Rev 1/2001

10

Prospital or Attending Property after death.
Funeral Director: After to

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ John William Spiker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany WMHS Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In yrs. last birthday) Funeral Dec. I3 1**X** M 2 □ F ¹⁷⁾1933 Maryland Director 76 Yrs. 217-30-1296 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 X No Garrett McHenry 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral USA 21541 255 Fysell Rd., Unite 34 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 🙀 Yes 2 □ No If Yes, Give Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Army National Guard Sat. 1st Class Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed trent of Health and Mental Hr trant; If item 27 is marked of ijury or other traumatic even မ Agnes R. Fazenbaker Harry L. Spiker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 Pysell Rd. #28, McHenry, MD 21541 Janice Spiker/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Department o Important: If any injury or Mt. Zion Cemetery Nov. 24, 2010 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, 21. Signature of Furtheral Service L Box 275, Grantsville, MD P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of Exami Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death Dav 5 Other (specify) sate has been signed by the page 2 should be detached Unknown Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1100 this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, it 25. Was case referred to medical o Death (Check only one) Be examiner? 2 🚺 Other: 은 epatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certified ပ

Registrar

31. Date filed (Month, Day, Year)
NOV 2 3 2010

Name and address of person who complete

Registrar's Signature

se of death (Item 23a) (Type, Print)

olatown

Road Cumber and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ a^{M} Norma Gean Shahan 2010 3:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 74 Shaffer Hill Road 0akland Garrett g. Birthplace (State or Foreign Country) WV 8. Date of Birth (Month, Day, 02 28 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours 1 □ M 2 🗷 F 1939 Director 233-62-8710 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Tyes 2 No Oakland MDGarrett 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō Funeral 23a 74 Shaffer Hill Road 21550 USA items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married ò þ 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Own Home Homemake Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Neal Hershman Annie Bell Waybright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s f Health item 27 74 Shaffer Hill Road, Oakland, MD 21550 Arlie E. Shahan-husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Garrett Co Memorial Gardens 11/23/2010 1 🗶 Burial 2 🗌 Cremation 3 🔲 Removal from State Oakland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 2nd St, Oakland, MD 21550 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) YVC Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burlal-tran that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a r use as the burlal-Physician/Medical death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown g Unknown Hospital or Attending Physician; The law requires that the 124 hours after death.
Funeral Director: After this certificate has been signed by th s been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 🗌 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1702333

Registrar

DHMH 17 Rev 7/2009

State

Thomas

4th

#2. Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson.

MD

311

N.

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Name (First, Middle, Last 2. Date of Death 3. Time of Death Month Physician/ 15PM Medical Facility Name (if not institution, give street and number or Location of Death 4c. County of Death **Examiner** Baltimore City If Under 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Min June 24, 1926 84 Director 215-20-4908 Marvland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoy 10a State 10b. County ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10752 Flower Street 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Navy Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐XNo Completed Year or Dates. 1944-1946 the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Showell Poultry Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ William Briddell, Sr. Hattie Smack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnie Smack/ Son 10650 Flower Street - Berlin, Maryland 21811 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State mportant: If 'n Department St. Paul UMC Cem. 11/18/2010 Berlin, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Salisbury, Maryland Chapel - 1213 Jersey Road 21801 Jollev Memorial 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last the attending physician Physician/Medical Box 68760 for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 1 Yes 2 No 9 Unknown 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an law perform funeral director, page certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury 28b . Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number MD ause of death (Item 23a) (Type, Print) Name and address of person who complete breene Street Baltimore Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

recent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Savinovich Herlinda Matilde 0001A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical alisbur If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 ☐ M 2**X** F Months Min 86 Ecuador 115-68-1676 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Princess Anne 1 Yes 2 X No Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 USA 30022 Deal Island Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 🕱 Yes 2□ No Specify: Ecuadorian Specify: hispanic "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **12** clothing desianer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental His marked of permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve 2 Helinda Marieta Coronel Carlos Jordan Flores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30022 Deal Island Rd., Princess Anne, MD 21853 19a. Informant's Name/Relationship (Type, Print) Rafael G. Savinovich/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Springhing Gardens
Springhinghing Memory
Gardens 1 X Burial 2 Cremation 3 Removal from State 11/16/2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) PANTISHAY PURE AL Home Professional Association 501 Show Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to physician and sthe burial-transit that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 - No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural
2 Acciden
3 Suicide 5 Pending injury after death. 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be the within 24 hours after de
To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 1.0.

32.

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a per med cert. G9101277710 dk
State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Margaret Elizabeth Schlimme 7:30 A M 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Smithsburg Washington 12216 Cloverly Farm Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year OCt . 10 , 1 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Country)
Washington DC Months Days Hours 1 □ M 2 🔀 F **Director** 577-46-7371 98 1912 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified et once. 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 X No Smithsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21783 U.S.A.12216 Cloverly Farm Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Margaret Butler Eppa Clifton Royston 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12219 Cloverly Farm Ln. Smithsburg, Maryland 21783 Betty Jo Ganley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State December Rockville, Maryland Parklawn Cemetery 4 Donation 5 Other (Specify) 2010 J.L. Davis Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final Physician/ acuto Cardiovarcular disease or condition resulting in death) POAR Medical Due to (or as a consequence of Examiner over 20 yrs Insulin Dependent Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) over 20 yrs Carotid Artery Stenosis Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi s been signed by the attending physician and should be detached for use as the hurial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dependent 2 No 3 Probably 4 Unknown diabetes 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has I autopsy performed? Yes 2 No death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical * 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\sum \) Other (Specify) Hospital: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) 29b. Signature and title of certified 29c. License number 30 11 7010 M.O. 0047234 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown MO 21742 Stranss Penns 3424 101 Vania 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 07** 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Κ. 2010 Jeanette Traum November 5:30 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill Nursing Home Bethesda Montgomery 5. Social Security Number f Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Ju^{(Mopth,}1^D3^y, Year) 914 96 Washington DC Director 577-50-9849 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director ¹X□ Yes 2 □ No North Potomac MD Montgomery with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 USA 14917 Dufief Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 № No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Kirsch Annie May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14917 Dufief Drive, North Potomac, Maryland 20878 Steven L. Canter, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State King David Mem. Grds. 11/12/2010 Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of anzansky-Goldberg Memorial Chapels, 1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licenses UC Greenhad MO1547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dusito (or as a consequence of; if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician sit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending when the funeral completed filled in by the funeral director. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury work 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057124 November 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD 10110 Molecular Drive #206, Rockville, Maryland 20850

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

**Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Medical

29a. Certifier (Check

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31. Date filed (Month, Day, Year)

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Registrar

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DHMH 17 Rev 7/2009

Registrar's Signature

			For State Registrar	State of Ma	aryland		artment o			and M	-	giene Reg. No	n ~ 1		38377
П	Physicia	n/	1. Decedent's Name (First, Middle, L.	ast) TRAN							2. Date of De Novemb	ath		Xear o	3. Time of Death 07:15 AM
	Medic Examin		4a. Facility Name (if not institution, gire	ve street and number)			4b. City, To			f Death	Novellin	4c.	County	of Death	
	Francis	DIT.	11621 Tall Pine 5. Social Security Number 6.		e (In vrs. las	st birthday)	Gern If Under 1	mant Year	own If Under 2	24 Hrs. T	8. Date of Bir		ontgo T	omery	ace (State or Foreign
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and	be filed ental H ked ot c ever	To B	17. Father's Name (First, Middle, Last Lich Tran)						r's Name TH1	(First, Middle, T.e	Maiden S	3umame))	
ary	hould and Me is mar		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	treet an			Route Numbe	r, City or	Town, St	tate, Zip Co	ode)
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		INTI	22	. Name and A	Address	of Facility	De	Vol Fun Five	eral	Hon	ie	iar y rand
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3760	ficate g phys as the	Medi	ISSENIE .	a											
Box 687	th certi tendin or use a	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal	death 3 [Ectopic pre					1	23d. Date Mon	e of deliver	ry Day Year
. B0	ne deat / the at ched fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (speci	ify)					IVIOI		Jay Teal
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Ę	Physic this ce al dire	은	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien	t 3 DOA	_	4 ⊔ Nu		me 5 K Resid				
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trinist or properties of the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Injur	ry - At hon . (Specify)	ne, farm, stre	et, factory, of	ffice		2	28f. Location (S City or Tow			r or Rural F	Route Number,
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	the Ho hin 24 the Fu Tipleter	Med	only one) 3 Certifying No	miner: On the basis of ex urse Practioner: To the b			leath occurred	at the t	ime, date			e cause(s) and mar	nner as sta	ted.
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	~~		30. Name and address of person who				rint)								
			Dr. Chitra Rajas					ente	er Dr	ive	#221,	Rock	vi11	e, MI	20850
	Sta Registra		NOV 16 20	32. Registra	s Signatu	ire do	del.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9, 201°0" Gilbert A. Tribby, Jr. 5:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2003 Cambridge Dr. Crofton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 2, 1930 1 🖾 M 2 🗆 F Months Days Hours Min. Washington, Director 579-34-3849 80 Yrs. Usual Residence of Decedent 10b. County 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2XNo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2003 Cambridge Dr. 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Exes 2 Q 191948— If Yes, Give 49153—55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Estimator Salesman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental ! 7 is marked o ည Gilbert A. Tribby, Sr. Mary Yassel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. Judith A. Tribby / Spouse 2003 Cambridge Dr., Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Congressional Cemetery 11/13/2010 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a Fart 1. Enter the sease, o plications that caused shock, or high failure. List only one cause on each line. isease, o emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cau e (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical attending p F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 ☐ Yes 2 L 9 ☐ Unknown ed by the a 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician; The law has page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 R Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled in 24 hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-40521 November 12,2010

State Registrar

Box 68760

P.0.

Records,

Division of Vital

O CHANE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 25 HOSPITAL DRIVE JUITE 208

SLEN BURNIE, MD

21061

		1 - State of Ma	ryland / Depa <i>Cer</i>	artment of Hertificate of L			ne No.	0 .	38379
Physici	an	1. Decedent's Name (First, Middle, Last) Elwood Stanley Taylor				2. Date of Death Month	Day	Year	3. Time of Death
/Medic	cal	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	11 08	20 4c. Count		1:10 p M
Examir	ıer	Holly Center		Salisbu			Wico		
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y			lace (State or Foreign
Director		220-76-2632 XDM 2DF 57	Yrs.	Months Bays	1.00.0	11-26-1	952	MD	
land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				1	0d. Inside City Limits
Mary a-f sh	to	MD Wicomico	Salisbur	V					1X Yes 2 □ No
or 28	Jirec	10e. Street and Number		10f. Zip Code		109	. Citizen of	What Cour	ntry?
ath w	lal	926 Snow Hill Road	140	21804	0-1-1-2 (6	US	_	ce - Americ	non Indian
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland other than "natural" or tems 23a or 28a-f show svent, I.e Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced	0	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 🌠 No		o Rican, etc.)	Bla	Blac	etc.
d 2 should be filed within 72 hours af this and Mental Hygiene. 71 is marked other than "nature!", or trsumatic svent, i.e Medical Exam	ted b	15. Decedent's Education	16a. Decec	dent's Usual Occupa	ation	deino 16	ib. Kind of E	Business/In	dustry
thin 7 e.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	life. L	kind of work done d DO NOT use retired,))				
led wi lygien her th	S	O	Disa	bled	10 Mathada Nor	ne (First, Middle, Ma)isab		У
8 6 5 8	Be c	17. Father's Name (First, Middle, Last) James Wesley Taylor				a Mae Di		110)	
s 1 and 2 should be if Health and Mental Item 27 Is marked of other trsumatic sys	은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a		ıral Route Number, (, State, Zip	Code)
		Theresa King/Sister	304	Purnell	St, Sn	ow Hill,	MD	2186	3
permit. Pages 1 ar Department of Hea Important: If Item is any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of matory or other plaq	%LC	Date 20	c. Location	- City or To	own, State
Pages ment of tant: If tt		4 □ Donation 5 □ Other (Specify)	Direct	Cremato	CV. 11_	16-2010	Dove	r,DE	
permit. Pages Department of t Important: If tte any tnjury or of		21. Anature II Funeral Service Licensee	22 B	2. Name and Addres ennie Sr	s of Facility 91	7 W. Isa	bell	a St	•
40240	1. 1/4	23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each lin	the death. Do not ent	uneral H	Iome Sa	lisbury,	MD_	2180	Approximate
Division		Immediate Cause (Final	•	LIVBR		•			Interval Between Onset and Death
Physician /Medical		resulting in death i	CNANT consequence of):	21012	CH	RCINDU	-1		
Examiner		Sequentially list conditions, b.							
D 15	iner	di any, leading to immediate cause. Enter Underlying Cause (Disease or injury	i consequence of).						
and and II-trans	Examiner	that initiated events c.	consequence of):					-	
ate be executed thysicien and the burial-transit	ical E								
tificate ig phy as the	edic	0.					_		
The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth		Ectopic pregnancy				ate of deliver	ery Day Year
it the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	time of death 5	Other (specify)			141	Onti	Day 16di
that thed by detact	F.	Part II. Other significant conditions contributing to death but	at not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use cor	ntribute to t	he cause of death?
ulres tha signed Id be del	d by			, , , , , , , , ,		1 □ Yes	2/1No	3 🗆 Prot	pably 4 □Unknown
w require s been si should l	Completed					24a. Was an	24b.		opsy findings available
The lav te has	E O					autopsy performe	ed?	prior to co death? 1 \(\text{Yes}	mpletion of cause of
	BeC	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			7
Physic this ce al direc	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien			4 Nursing r	lome 5 Residen			WHOLLY CANTI
l or Attending Physicten: " after death. Director: After this certifica in by the funeral director, p	ion:	27. Manner of Death 28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	Work	/at <br Yes 2 ∐ No	28d. Describe how	injuty occu	irred	,
Attending Physiclan: or death. •ctor: After this certific. by the funeral director,	ertification:		ıry - At home, farm, str			28f. Location (Stre	et and Num	ber or Rur	al Route Number,
after Dire d in b	ert	4 Homicide determined building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,	State)		
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and me and place	nanner as s , and due t	stated. o the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier		29c. License		1	_		Day, Year)
1		15000	MI	Doc	5841	0	11-0	8-10	0
W)		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)	Δ. Δ.	o lwy		7 :	4
1		GHULAM WARY PO	130-	1733 5	Heis!	wy	m)	11	400
St Regist	ate rar	Klift/ a'ss DD4D 81	ar's Signature	barker		/			-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vennis Novemberi 11:48 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign 1 X M 2 □ F Days Hours Country) 214-68-7459 **Director** 55 1955 Deläware Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Caroline Federalsburg 1 🗆 Yes 🚈 No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27997 Bloomery Road 21632 United States Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trailer Repair 12 Trailer Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice E. Shaffer Marion L. Tull, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27997 Bloomery Rd., Federalsburg, MD 21632 Pam M. Tull/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State Bloomery Cemetery 11/18/10 Smithville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratoru Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 daus Pulmonary Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina Accident Investigation 1 🗌 Yes 2 🗎 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Nebec Leve

State Registrar REBECCA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

4940

32. Registrar's Signatur

DEZUBE

NOV 1 8

RES-000

EASTERN AVENUE

November 14,2010

BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9 Hattie Irene Urquhart 2010 5:38 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Min. Hours (Month, Day, Year) an. 3. 1921 214-12-9092 Director Yrs 89 Jan. Usual Residence of Decedent or 28a-f shov 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Wicomico 1 ☐ Yes 2 X No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 403 Bueclar Street 21801 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injuy or other traumatic event, the Meone. than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Barrett Minnie Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Legrand Seward/ Daughter P.O. Box 405- 1777 Grand Concourse - Bronx, NY 10461 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Springhill Memory Gardens 11/22/2010 Hebron, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel -1213 Jersey Road 21801 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail in the past 12 months? Month 5 Other (specify) Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎘 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No this certificate 2 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work?
1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the within 2

31. Date filed (Month, Day, Year) Registrar

Medical

29a, Certifier

(Check

only one) 29b. Signature and title of certifier

anna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

910 Easternshore Dr Salisbury MD 21804

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	,	Department of Certificate of				Reg. No.	2010	38382
	Physicia		1. Decedent's Name (First, Middle, L.	ast)		11AnIMF	-T/=	P	2. Date of Dea Month	ath	Year	3. Time of Death 1336 M
	Medic Examin		4a. Facility Name (if not institution, gi	e street and number)		4b. City, Town,			-//-	4c.	County of Dea	
1			WMH5 - RMC 5. Social Security Number 6.	1 Sex 7. Age	(In yrs. last birth	day) If Under 1 Yea	n BE		8. Date of Birt	#/	9. Bir	rthplace (State or Foreign
	Funeral Director		233-44-5241	1 🛛 M 2 □ F		rs. Months Day	s Hours	Min.	02/26/2	438	CUM	BERLAND, MD
	show show	l. I	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl 28a-f lotified	irect	WV		RIDGELE					10- 00	CANDON C	1 X Yes 2 □ No
	vith the 23a or st be n	Funeral Director	10e. Street and Number 68 BLOCKER STR	EET		10f. Zip Code 26753				USA	zen of What C	ountry?
	items		11. Marital Status	12. Was Decedent Ev		13. Was Decedent of If Yes, specify Cu	Hispanic C	Origin? (Specan, Puerto I	cify Yes or No- Rican, etc.)	1	14. Race - Ame Black, Whit	
936	e filed within 72 hours after death with the Maryland ta filed within 72 hours after death with than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	g p	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 X Yes 2 1 N If Yes, Give Year or Dates.	10	1 ☐ Yes 2 💢 N	No Speci	fy:			Specify: W	HITE
- - -	2 hours "natur edical	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Occ (Give kind of work don	e during m	ost of workii	ng	16b. Kir	nd of Business	Industry
2121	vithIn 7 jiene. sr than the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5-	-)	life. DO NOT use retire HANDYM				CC	NSTRUC	TION
Maryland 21215-0036	e filed varial Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last GERONE VERNON V						e (First, Middle, WAXLER	Maiden S	Gurname)	
<u>37</u>	should be file and Mental I is marked c raumatic eve		19a. Informant's Name/Relationship		19b.	. Mailing Address (Street				er, City or	Town, State, Z	ip Code)
ž	1 and 2 should be f Health and Men ttem 27 is marke other traumatic		ROBIN PEER			RT 1 BOX 5	88 RI					T Chala
nore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe	Removal from State	cemeter	Disposition (Name of y, crematory or other page VAU			0/2010		cation - City o	
Baltimore,	permit. Page Department Important: Il any injury or once.		21. Signature of Funeral Service Lice		/	22. Name and Add	fress of Fac	cility WVU	HUMAN	GIFT	REGIS	
	20 = e 0		23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do n						20300	Approximate Interval Between
- P	hysician/	1	shock, or heart failure. List only Immediate Cause (Final disease or condition	. Cardi		rrest						Onset and Death
	Medical Examiner		resulting in death)	0 1	consequence of	on: A						
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last		consequence of		764	<i></i>	<u> </u>			
09	nte be e hysicia the buri	edical	•	■ a	<u>D</u>							
687	pertifice ading passe as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	3 ☐ Ectopic pregn	2004				23d. Date of de	elivery
Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown		5 Other (specify)					Month	Day Year
P.O.	that the ned by t detach	by Phy	Part II. Other significant conditions	contributing to death bu	ıt not resulting i	n the underlying cause	given in Pa	art I.				o the cause of death?
ds,	equires sen sign ould be		ATN									Probably 4 Onknown utopsy findings available
ecol	e law re e has be ge 2 sh	Completed							24a. Was auto perfo	psy ormed?	prior to death?	completion of cause of
a B	sician: The law i certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical examiner?					eath (Check		2 (2 (0)		2 2 110
Ę.	Physicia this cert ral direct	은	1 ☐ Yes 2 ☐No 27. Manner of Death	28a. Date of injur	y 28b. 7	itpatient 3 A, DOA 28c. In	iurv at		me 5 Resi			cify)
o uo	anding F sath. or: After he funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat			M 1	ork?					
Division of Vital Records,	Il or Attend after death Director: /	Certi	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry - At home, fa . (Specify)	rm, street, factory, offic	ce		28f. Location (City or Tox			ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Eve	hysician: To the best of miner: On the basis of ex	amination and/c	r investigation, in my or	inion, death	n occurred at	t the time, date a	and place.	and due to the	cause(s) and manner stated.
	To the I	M	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practioner: To the I		29c Lice	nse numbe	er		29d Dat	e signed (Mon	
			Sinds	Dee	ARN	PR	16.	744	8	11-	19-	10
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, Print) Glenn (umb	erp	NO 1	n B	215	0 2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	bares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy Watts Physician/ May Year N6♥.8,2010 2:31a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10 Pimlico Court Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Days Hours Min. 1290 44 1 937 72 OTTO 220-40-5271 **Director** Usual Residence of Decedent or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location
Silver Spring Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery MD 1 □ Yes 2 🕇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 Funeral 10 Pimlico Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛂 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Halterman 17. Father's Name (First, Middle, Last) Oliver Eaton ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ronald Watts/husband 10 Pimlico Court Silver Spring, Md 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State George Washington 11/11/201 0 Adelphi, Md 4 Donation 5 Other (Specify) 22 Malle Lette Podd Bs. of Letter ALDI FUNERAL SERVICE, P. A 21. Signature of Funeral Service Lice 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4mo • Immediate Cause (Final Relapsed non Hodgkin lymphoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the sahould be detached 1 ☐ Yes 2 € 9 ☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by metastaic breast cancer 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛚 No Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 2 🗌 No 1 Yes Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Records, To the Hospital or Attending Physician: Ine within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Division of Vital

Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year D0058879 November 9,2010 all Houm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orleans Street Baltimore, Md. 21231 Suite 389 Yvette Kasamon M.D.

State Registrar

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2 Date of Death

			1 - State Registrar		tificate of De			eg. No. 2 0 1 0	38385
	Physicia		1. Decedent's Name (First, Middle, Last) Carolyn Joyce White				2. Date of Death Month	Day 27 Year	3. Time of Death
-	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Deatl		4c. County of De	1000
and the same	,		TENINSULA ROGIONAL MEDICAL CENTU		544	SHRY			NICO
	Funeral Director		5. Social Security Number 217–52–0463 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last	birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) April 29	(ear) 9. B	irthplace (State or Foreign country) MD
	and show Lat	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Loc	ation				10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD Wicomico Sa	alisbu	ıry				1 🄀 Yes 2 □ No
	th the	alD	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	Country?
	ath wi	Funeral	803 Price Road 11. Marital Status 12. Was Decedent Ever in U.S.	13 W	21801 as Decedent of Hispa	anio Origin? (Sr	point Von or No	US	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo 1 ☐ Yes 2 ☐ Mo 1 ☐ Yes Give Year or Dates.	lf lf	Yes, specify Cuban, I	Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh Specify:	
15-	72 ho n "nat Aedica	Completed	(Specify only highest grade completed)	(Give ki	ent's Usual Occupation and of work done duri	on ing most of won	king 1	6b. Kind of Busines	s Industry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired) Aycare Pro	vider		Self-En	mployed
nd	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	iden Surname)	
Maryland	should be and Ment is marked raumatic e	_	Walter Harmon				helia Lor		
	and 2 sho Health an tem 27 is		19a. Informant's Name/Relationship (Type, Print) Harry T. White/husband		Address (Street and Price Road				lip Code)
Baltimore,	ge 1 and of the or othe		20a. Method of Disposition	e of Disnos	ition (Name of	Jairs		Oc. Location - City o	r Town, State
Ħ	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee	mory	Gardens	Nov	12,2010	Hebron, M	ID
B	Dep Imp any onc	1	Jalana D. Walson	1€	Name and Address of Wis N. Wa 518 West Re	tson Fu d.,Sali	neral Hom sbury,MD	e, PA 21801	
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter	the mode of dying, s	such as cardiac	or respiratory arrest	,	Approximate Interval Between
LI	hysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence)		minary	cubo	(15h)		Onset and Death
	Examiner	_	Sequentially list conditions, b.	Jo May.)				
	pe sit	Examiner	Fary, leading to him culate cause. Enter Underlying Cause (Disease or injury	se of,					
	ificate be executed of physician and as the burial-transit		that initiated events resulting in death) Last c. Due to (or as a consequence	ce of):					
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68760	ertifical ding ph		IF FEMALE:						
Box (law requires that the death certificate be executed nas been signed by the attending physician and 2 Should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deatl	eath 3 🔲 I	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
P.0	v requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause given i	in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds,	equires een sig rould b	ed	acute renal Failure.				1 🗌 Yes	2 No 3 F	Probably 4 Unknown
000	has by	Completed					24a. Was an autopsy	prior to	topsy findings available completion of cause of
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\ Kalendaria	nysicia iis cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatient	Othors	of Death (Chec		e 6 🗆 Other (Spec	Nife (
to	ing Pr			o. Time of injury	28c. Injury at work?		28d. Describe how		201)
SIO	death ctor: / ctor: / y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	farm etree		2 🗆 No	205 1		10 1 11 1
Division of Vital Records,			building, etc. (Specify)				City or Town, S		
:	n 24 hor n 24 hor ne Fune oleted fi	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one) Certifying Nurse Practioner: To the best of my knowledge only one	d/or investig	ation in my oninion d	leath occurred at	the time date and -	loop and due to the	an in a land and an an an at at and
	vithi To th		29b. Signature and little of certifier	,	29c. License nur	mber		. Date signed (Monti	
	6mg	-	Ifferile or allending playse	uan.	H0059	368		11/5/10	
1	ν		30. Name and address of person who completed cause of death (Item 23a	(Type, Prin	.+\	shum -	ND 218	70/	
	State Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Soa	Kel				

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM Ε. YOST JR. NOV Medical 2010 3:16 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6627 AYRES LANE ROAD SNOW HILL WORCESTER 5. Social Security Number Funeral If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Year 1961 1 X M 2 □ F Months Days Hours Min SEPT 5 Director 49 219-90-2597 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DELAWARE SUSSEX SELBYVILLE 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 37239 YOST ROAD 19975 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò þ 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) CUSTOM PAINTER BUILDING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: if item 27 is marked of any injury or other traumatic events. ပ WILLIAM Ε. YOST SR. VIVIAN SLEEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37239 YOST ROAD, SELBYVILLE, DELAWARE 19975 VIVIAN F. YOST/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location ~ City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) CREMATORY OF DELMARVA 11/20/2010 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature / Funeral Service Light 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset an Death immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner Sequentially list conditions, Examine if any reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Day 2 No Year ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed certificate Yes 2 N funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 973 31. Date filed (Month Day, Year 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Delores Weller Younker Tnez 6:50pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death the HOSpice 1.a a MIC Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Hours Min. 210-26-5416 04/14/1933 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 X No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 117 Shamrock Drive 21804 USA items ? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc "natural", or ş 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Completed 3 Widowed 4X Divorced white Specify Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) certified nurses aide health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Homer E. Weller Mabel Charlotte Younker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Shamrock Dr., Salisbury, MD 21804 Christy L. Behan/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/17/2010 ☐ Donation 5 ☐ Other (Specify) Stenger Hill Fort Loudon, PA Tricon S wice Lic nsee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Compror CFSP Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) a CHRONIC OBSTRUCTIVIZ DISRASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. day, leading to infriedrate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No . Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? Yes 1 🗌 Yes thin 24 hours after death.

the Funeral Director: After this certific mpleted filled in by the funeral director, 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Be 26. Place of Death (Check only one) Hospital မ Other: HOSPICIZ 1 Inpatient 2 I ER/Outpatient 3 I DCA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier မ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Huysun 130 X 21002 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

NUV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Imer Town 2350 2010 11 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MI Kel 11552 Stone Mountain Little Orleans, Allegany 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 219-52-188 Director Usual Residence of Decedent with the Maryland 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, it a Medical Evaniner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No 16 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21766 Outain S.H death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be ဂ Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any injury or other trau
once. DUNK 552 Stone Moudain Rd, Little Orleans, Md 21766 Victoria 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State emetery 12-4-2010 Little Orleans, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Ficility
Hunter-Anderson Funeral Home
310 S. Green Street Berkelei Springs, lov 21. Signature of Funeral Service Licensee 25411 23a. Part 1. Entecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sclerosis **Physician** tmyo trophic 09-11/34/10 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir requires that the death certificate be executed and burial-Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 was and autopsy performed?

Ves 2 No he age certificate Vital 1 □ Yes 2 □No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ Ño Other: 4 \(\sum \) Nursing Home Certification: To 1 Inpatient oţ 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 🗆 Yes 2 TNo the 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 66 9 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day)

DHMH 17 Rev 1/2001

Registrar's Signature

Denewa

Industrial Bird Cumboland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			For State State Registrar	e Of Marylai		artment of F tificate of D			Reg. No	0010	38389
	Physicia	n/	Decedent's Name (First, Middle, Last) On the second of the second	t-f	7	.0.0		2. Date of De Month		1, 2010	3. Time of Death
,	Medic Examin		George Pa 4a. Facility Name (if not institution, give street and	nayotis number)	Zepp		Location of Death	Novemb		. County of Death	8:15 P.M
	LXamin	C1	Montgomery General Hos			Olney			"	Montgon	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	9. Birth	nplace (State or Foreign ntry)
П	Director		226-76-0864 Usual Residence of Decedent	6	7 Yrs.			Jan. 2	3, 1	943 Gr	reece
	and show	ō	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation	· · · · ·				10d. Inside City Limits
	Maryla 28a-f	Director	Maryland Montgomery		Gaither	sburg					1 🗌 Yes 2 🔀 No
	a or 2 be no	Ξ	10e. Street and Number			10f. Zip Code	_		10g. Ci	tizen of What Cou	ıntry?
	h with	Funeral	24300 Welsh Road			20882				nited St	ates
	r deaf or iter		Armed	Decedent Ever in U. Di Forces?	S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		 Race - Ameri Black, White 	
990	s afte ral", c Exam	q pé	If Yes,	∕es 2. XX No Give r Dates.	-	I ☐ Yes 2 🛣 No	Specify:			Specify: Wh	nite
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Maryland 21215-0036	hin 72 ne. than '	omi	Elementary/Seconday (0-12) Colleg	e (1-4 or 5+)	life. D	O NOT use retired)	uning most of work	ng		16 7 1	,
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	d 2 sh ealth a n 27 ie ertra		Andriana Zeppos/Spouse		· I	Welsh Ro			-		
ore	of Healt of Healt if item 2 r other		20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 □ Removal f			sition (Name of natory or other place	e) [Date	20c. L	ocation - City or T	Town, State
<u><u>ä</u></u>	. Page ment o tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify)		$\overline{}$	Cemeter					Maryland
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Funeral Cervice Licenses	0.0	1.	2. Name and Addres					
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of			27. Manner of Death 28a. D	ate of injury Month, Day, Year)	28b. Time of injury		at	28d. Describe			
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Division of Vital Records,	or Att	Certificate:	4 Haminida determined 286, PI	ace of Injury - At he uilding, etc. (Specif		eet, factory, office		28f. Location (S City or Tou		nd Number or Rura e)	al Route Number,
Ω	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		29a. Certifier Certifying Physician: To the	ne best of mv know	rledge, death of	occured at the time	date and place, an	d due to the ca	use(s) ar	nd manner as stat	ted.
	n 24 h	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination	n and/or invest	tigation, in my opinio	n, death occurred at	the time, date a	and place	e, and due to the c	ause(s) and manner stated.
_	To th comp	-	29b. Signature and title of certifie			29c. License	number		29d. Da	ite signed (Month,	, Day, Year)
	12		· pu //	- Hospit	alist	D00	59414		11	/12/20	10
			30. Name and address of person who completed of Vladimir Rakhmanin, M.D.				Drivo 01	nev W	1		,
	Stat		31. Date filed (Month, Day, Year)	. Registrar's Signa			DIIVE, UI	iney, Ma	гута	110 20032	-
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	Medic Examin	cal	4a. Facility Name (if		, give str	eet and nun	nber)			4b. City	Town, or	Location	of Death	Decen		c. County	OIO of Death I/A	1010	<u> </u>
	Funeral		5. Social Security N 239-60-3	umber	6. Sex	M 2 🗆 F			st birthday) Yrs.	If Unde	r 1 Year Days		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)			place (State	
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0	with the I 23a or 2 ust be no	Funeral Director	10e. Street and Nur 1339 Si		orne	Road	ì			10f. Zij	Code	2	1239		10g. C	itizen of \	What Cou	ntry? USA	
355	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. I Department of Health and Mental Hygiene. I Department of Health and Mental Hygiene. and the majoriant if item 27 is marked other than "natural", or items 23a or 28a-f sho mortant if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Marr 3 Widowed		ried	2. Was Dece Armed Fo 1XXYes If Yes, Giv Year or Da	orces? 2 \[\] N ve	T Ter	ık.	Was Deced If Yes, spe 1 Yes				cify Yes or No- Rican, etc.)			ck, White,	can Indian, etc. Black	
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		State of Maryland / Depa		lental Hygie	ene	20001
			tificate of Death	Reg	. No 2 U 1 U	38391
Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
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Z	ier	Northwest	4b. City, Town, or Location of Death Randall Stown	,	4c. County of Death Balti	0.100
Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0.001	place (State or Foreign
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the Nr or 2	Ē	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	
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Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe			Name and Address of Facility Aug.	ha G. Gree	ne Funera	Bervices
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		Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
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VISION OI or Attending Pi tter death. irector: After th n by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	Bf. Location (Street City or Town, Sta	and Number or Rural I	Route Number,
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Hos 24 hc Fune eted f	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence (Check 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred at the	e time date and als	ace and due to the cause	se(s) and manner stated
LIVISION OF VICAL RECORDS, P.O. BOX 68/600 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burnary of the funeral director, page 2 should be detached for use as the burnary at the page 2 should be detached for use as the burnary at the page 2 should be detached for use as the burnary at the page 2 should be detached for use as the burnary at the page 2 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the page 3 should be detached for use as the burnary at the burnary at the page 3 should be detached for use as the burnary at the burnary at the page 3 should be detached for use as the burnary at the		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, der 29b. Signature partitle of fertifier	ath occurred at the time, date and place, 29c. License number		se(s) and manner as star Date signed (Month, D	
		Jan Min mi	D0062650		12-6-10	
, ()		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	nt)			
10		lanveer (anb. 5401 old lowt 1	road Randallstown	NMDZ	1133	
Stat Registra	e ir	31. Date filed (Voath Day, Year) 32. Registrar's Signature				
		LANDVA G. Surka				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year STEVEN 23:17 /Medical 24 2010 Nounber 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore The John Hykins Bayview Medical Certe Social Securify Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Date of Birth (Month, Day, 1 M 2 □ F Months Days Hours ^{Year)} 1959 220-74-4484 51 Yrs. Director January Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Md. 1 X Yes 2 □ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1223 Frailey Way 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No White Specify. Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If item 27 Is marked other i any Injury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer M.Ayers Dorothy Bitzel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Ayers Spouse 1223 Frailey Way B alto, Md. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview 4 □ Donation 5 □ Other (Specify) 11-30-2010 Balto, Md. 21224 21. Signature of Fun 11 grice Lic. 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mamorie ruces /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? Yes 22000 certificate 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1/2 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician;

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

TACKETT

DEC 0 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

824

5 130ND

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

RES-000

BACTIMORE

November 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month narie 05:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ochraven en Baltimore Baltimore . Sex 1 🖾 M 2 🗆 F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye December **Funeral** 9. Birthplace (State or Foreign Months Days ^{Year)}7,192 Hours Min Country land Director 3 214-12-9889 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene. I show that Hyglene is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or 28a-f sho is marked event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Balto. 1 Yes 2X No Md. Nottingham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8723 Blairwood Road #83 21236 USA 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Truck Driver Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic ev Naomi Silvers Charles Appell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Dulaney Drive Jarrettsville, Md. 21084 Thomas Ayres Step-son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 \(\) Burial 2 \(\) Cremation 3 \(\) Removal from State 4 \(\) Donation 5 \(\) Other (Specify) cemetery, crematory or other place, 12-7-2010 Dulaney Valley Timonium, Md. 21. Signature of Funeral Service Linenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated every injury) Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manuar of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ure and title of certifier 29d. Date signed (Month, Day, Year) 6

State Registrar 31. Date filed (Month, Day,

Year.

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Mar		partment of I Partificate of I		Mental Hy	21	110	39301.
			Decedent's Name (First, Middle, Las	")		Timodic or i	Jean	2. Date of De	Reg. No. 🛴 🚶	<i>)</i> U	3. Time of Death
	Physicia Medic		Albert Antone	211i				Month Dec	3 Day	2010	1:03 A M
	Examir		4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Deatl		1	nty of Death	1
"	<u>-</u>	М	Gilchrist Hospice 5. Social Security Number 6. Se			Towson					County
I	Funeral Director		185-18-0828	7. Age (III	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Sept,	rth ay, Ye <i>ar)</i> 13,1923	9. Birth: Coun It	place (State or Foreign try) aly
	ind show at	5	Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or L	ocation				1	0d. Inside City Limits
	//aryla 8a-f s tified	rect	 Maryland Anne Aru	ınde1	Brooklyn					[]	1 X Yes 2 □ No
	the Na or 2	٥	10e. Street and Number	inder	DIOUKLYII	10f. Zip Code			10g. Citizen o	f What Cour	
	n with	Funeral Director	5506 Ballman Aver	ue		21225			U.S.A.		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo	in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	BI	ace - Americ ack, White, e	etc.
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Baltimore, Maryland 21215-0036	Page 1 ar nent of Ho ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State		osition (Name of matory or other place PK Cemeter	e) Dec	Date 7 010	20c. Location	·	
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service License	eebl Mo	1594 2	2. Name and Address Services I	ss of Facility Si	ngleton	Funera	1 & C1	remation
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DHMH 17 Rev 7/2009

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P		5. Social Security Number 6. Sex	land Mad.	Centes	Balta	more			N,	/A	
Funeral Director			M 2 □ F 7. Age (Ir	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day	Year 1939	9. Birthp	place (State or Foreign try) 7 Land
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Ma 2 sh Ith ar 27 is trau	ĺ	19a. Informant's Name/Relationship (Type Mrs. Joan M. Ammo	. ,	19b. Mailin 2038	g Address (Street a. Shore Roa	nd Number ad Di	or Rural Rout undalk	te Number, Mar	City or Town, S y land	^{tate} Zio C 21 222	pde) -
IMOre, I Page 1 and 2 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispos cemetery, crem Hilltop S	atomi or other place	orn	Date 12/4/20		20c. Location -	-	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee			Name and Address 1da-Ruck 922 Wise						
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North Volth		29b. Signature and title of certifier			29c. License n	umber			d. Date signed		
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10		30. Name and address of person who com		-	11)						
Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Si	REEN ST	Bally	MONY	, YX)	21201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 00 AM 0 an 0 2010 le cemper 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7308 Conley St. 5. Social Security Number 6. Sex Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2⊠ F Months 234-05-8763 17,1916 Mar. Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore County 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7308 Conley St. 21224 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Federal Government N/A Investigative Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Pilcher Laura Leonhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Zaras (Daughter) # 16 Glade Avenue Baltimore, Md. 21236 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12-9-2010 Baltimore, Md.

22. Name and Address of Facility

Lassahn Funeral Home

Pnysician /Medical

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

the Marylend woye

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 20.0s.

Baltimore, Maryland 21215-0036

MR

Division of Vital Records, P.O. Box 68760,

or Attending Physicien:

To the !

death.

Examiner The law requires that the death certificate be executed

Examiner sete hes been signed by the attending physicien end pege 2 should be detached for use as the burial-transit Physician/Medical ģ Completed this certificate director Be ၉ After this funeral of Certification: Director: / within 24 hours after of To the Funeral Direc completely filled in by

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 menths? 1 ☐ Yes 2 Ø No

IF FEMALE

21. Signature of Fundral Service Lice

Due to (or as a consequence of):

ongestive

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

7401 Belair Rd.

Baltimore, Md. 21236

Day Year

Approximate Interval Between Onset and Death

reass

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

isease

24a. Was an autopsy performed? 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death Check on one Other: 4 Nursing Home 57 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? м

Johns

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

mean omas

HOPKINS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS

29a. Certifier

FINEL (ANE 32. Registrar's Signature

State Registrar

10-09026	
Thomas Bethea	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

omas	Bethea		State of Maryland / Department of Health and Me 1- For State Certificate of Death	2010 0000
/)		Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death 3. Time of Death
edical	Physici Exami	an/ iner	Kathan	Month Day Year 1056 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locatio	
			Franklin Square Hospital Rosedale	Baltimore County
_	uneral			nder 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
	irector		Months Days Hou	Country 1
			053-58-1092 1 M 2 F 43 Yrs. W	1-1-176/ Counterolin
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limi
\mathcal{O}	0 V 2		11 B 11: B-16: 11/12	1 Yes 2 📈 N
28	-f sh	tor		10g. Citizen of What Country?
T	r 28a ed at	Director	25 - 2 / 0 04 5 - 2	/ 1 C /
	23a o 10tifi		3509 Branch Court Rd 21234	U.S. #.
- A	ems (Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C 14. Was Decedent of Hispanic C 15. Was Decedent of Hispanic C 16. Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- ian, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
2	or it	Fur	1 Yes 2 No	r Block
affe s	ral",	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specifor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Given the complete of the	17
,	'natu Exar	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
36	han dical	ple		Vinctor Alexand Polabilt
Ö 🕏	giene her t	omo	17. Father's Name (First, Middle, Last) 18. Moth	her's Name (First, Middle, Maiden Surname)
215-0036	t, th	Be C	Tal All A	11. 4 4
212	Mentz nark even	o B	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	lumber or Rural Route Number, City or Town, State, Zip Code)
more, MD 21215-0036 Pages 1 and 3 should be filed within 73 hours after death with the Mandam	ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	-	Aller Botton in 22 Facle St.	Selden New York 11784
≥ c	ealth tem 2 traun		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
ore 1	of H If it		1 Bunal 2 Cremation 3 Removal from State crematory or other place)	KI:
E &	ment tant:		4 Donation 5 Other Specify: KUSEMOUN CREMATORY	12-11-2010 C1, LABETH, N.J.
Baltimore,	Department of Health and Mental Hygene. Important: If item 27 is marked other th injury or other traumatic event, the Med		71. Signature of Funeral Service Licensee	ouglass Euneral Service P.A
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	s cardiac or respiratory arrest, shock, or heart Approximate Interv
	⁄sician ledical		failure. List only one cause on each line.	Between Onset an
	miner		Immediate Cause (Final disease a. Cardiomgaly	Death
			or condition resulting in death) Due to (or as a consequence of):	
		Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
		Examiner	cause. Enter Underlying Cause	
À	, ii	xar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
A parinted	sician and urial - transit	a E	d	
8	ician	dical	X UNPENDED AMENDED 23a, PII, 27, per ME g910 12/13	3/10 TT
760	e attending physic for use as the bur	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
68	nding se as	ian	past 12 months?	pic pregnancy Month Day Year
ŏ	e attendi for use	sic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)	
.	by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e. Did tobacco use contribute to the cause of death?
O. 4	After this certificate has been signed by the funeral director, page 2 should be detached for		Liver steatosis	1 Yes 2 No 3 Probably 4 Unknown
Š,	en sig	Completed by	Liver steatosis	24a. Was an 24b. Were autopsy findings availab
0.0	as be	ple		autopsy prior to completion of cause of performed?
Sec	cate h	mo:		1 Ves 2 No 1 Ves 2 No
<u> </u>	ertific	Be C		th (Check only one)
Zit.	this c	To E	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other4	Nursing Home 5 Residence 6 Other:
وَّ وَ	After		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Wo	ork? 28d. Describe how injury occurred
on	ath. or: / the fu	Certification:	1 Pending 1 Yes 2	No
Visi	ter de irect in by	fice	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building,	
يَّةُ	urs af ral D Illed i	erti	4 Homicide determined (Specify)	or Town, State)
)	24 ho Fune tely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	
/ }	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	
È	\$ ₹ 8	Me	29b. Signature and title of certifier 29c. License numb	per 29d. Date signed (Month, Day, Year)
	,		O.C.M.E.	November 25, 2010
	6		30. Name and address of person who completed cause of death (Item 23a)	
	N		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	S Reais			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 25,27,28a-f per me 9910,12/08/2010dhb
State of Maryland / Department of Health and Mental Hygiene

Amend Item 21 per fh,g910,12/02/2010dhb

Certificate of Death

Reg. No. 2010 State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Booker Ann 11 <u>12:3</u>5A[™] 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum <u>Anne</u> <u> Arundel</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF (Month, Day, Year) 04/19/193 Country) **Director** 78 Yrs. 451-46-5372 Texas Usual Residence of Decedent Show or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 XNo Anne Arundel Severn ms 23a or must be n 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7929 Green Moss Glen 21144 U.S.A. "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify: White al Hygiene. d other than "natura" event, the Medical E Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important; If item 27 is marked other to any injury or other traumatic event, the once. Computer Programmer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Savage Mattie Phaff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Sandra R. Booker / Daughter 12707 Wynfield Pines Court St. Louis, MO 63131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2010 Glen Burnie, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 2nd Avenue SW Glen Burnie, MD per DVR Travis J. Hatfield Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day the 1 ☐ Yes 2 ₹ 9 ☐ Unknown 9 Unknown P.O. ò signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, has been sign 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of , page performed death? certificate Yes 2 No 1 🗌 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes Hospital: 2 1100 Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 1050 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate 28c. Injury at 28d. Describe how injury occurred atural 2 Accident 5 Pending work? November 1,2010 5:30 p^M 1 Yes 2 X No Subject fell Investigation To the Funeral Director; completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7929 Green Moss Glen, Severn, MD determined Home 24 hours hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) Name and address of person who 15 M 6 305 Hogo; Jal 0

State Registrar 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 11 per spouse G914 4/4/11 dk

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g910, 12/08/2010dhb

Registrar Certificate of Death

Reg. No. | | | | Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Year BROOKS KERMIT 9:00 MG Og. Medical 2010 NOI 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HARBOR HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 216-44-9166 Months Hours Min. July 31, Year 47 Director Yrs Country) MD 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Glen Burnie MD Anne Arundel 1 Yes 2x X No 10e. Street and Number 10 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 21060 223 Cherry Lane USA items death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ Never Married 2 Married 72 hours after "natural", or Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Too1 12 Laborer Be Department of Health and Mental H Important. If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Anderson Kermit F. Brooks Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Cherry Lane, Glen Burnie, MD 21060 Ella Anderson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery Nov. 15, 2010 Brooklyn, MD Signal of Funeral Service L 22. Name and Address of Facility
Fink Funeral Home, P.A. M01148 426 Crain Hwy. S., Glen Burnie, MD 21061 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. Ust only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RIGHT SUBDURAL HEMATOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to municipate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Dire to for as a nonsequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Pregna. ☐ Unknown Month Day as been signed by the a should be detached 1 ☐ Yes ∠ ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS TYPE 2 1 Yes 2 No 3 Probably 4 Unknown HEART FALLURE CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 X Yes 2 E No Hospital ျှ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Kuliano Abmeldo RESOOI NOV 09 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALMEIDA UCIANA 5 HAND VER ST BALTIMORE. 3001 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		artment tificate			nd Me		2		3.81	. 0 0
	Physici	an	1. Decedent's Name (First, Middle, Las				···········	0, 50	Julii		2. Date of Dea Month	Day	Year	3. Time of I	
	/Medio		JOHN WILLIAM BAR 4a. Facility Name (If not institution, give HCR - MANOR CARE				4b. City, To				ovember		2010 unty of Death	4:15 RGE'S	Рм
	Funeral Director		5. Social Security Number 6. Se	7. Ag	e (In yrs. Ia	ast birthday) Yrs.	If Under 1	Year II	f Under 24 Hours	Min.	B. Date of Birth (Month, Day, arch 13,	Year)	9. Birthp Coun	lace (State or	
	ith the Maryland or 28a-f show e notified at	Director	10a. State 10b. County DC 10e. Street and Number			Town or Lo	n 10f. Zip C				1	0g. Citizen	10d. Inside City Limits 1 ☑ Yes 2 □ No 0g. Citizen of What Country?		
336	d within 72 hours after death with the Maryland giene. If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	4513 7th Street, 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		1	Vas Deceder f Yes, specify	nt of Hispa Cuban, I	anic Origii Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		USA Race - America Black, White, of		
21215-0036	thin le.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 8th	ucation de completed) College (1-4or 5	i+)	(Give life. L	ent's Usual (kind of work o OO NOT use o	done duri retired)	ing most o			Priva		lustry	
Maryland	hould be fil d Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last) John William Nath 19a. Informant's Name/Relationship (7)		our	10h Mailin	a Address (C		Mart	ha E	First, Middle, M lizabet	h Cor	rum		
re, Ma	s 1 and 2 s f Health an tem 27 Is i		Laverne Johnson -	,	20b. Pla		Dopp1e	r St			Route Number al Heig	hts,		743	
baltimore,	permit. Pages 1 and 2 should be filed will be partment of Health and Mental Hygier Important; If Item 27 Is marked other than any inlury or other traumatic event, the once.		1 Burial 2 Cremation 3 La 4 Donation 5 Other (Specify 21 Signature of Funeral Service Licens)		Lincolr 22	Cemet	cery Address o	of Facility	John	/2010 son & S	Brent Jenki	wood, M	larylar ral Ho	me
	Physician [°]		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused ine cause on each lin	the death.									Approximate Interval Betw Onset and De	/een
\$00/00	Medical Examiner physician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or a	CA 1	ence of):	C 10	(fA)	RC	Tion	4				
O. BOX 6	The law requires that the death certificate tee has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗀 Fetal (death 3 🗌	Ectopic pregi Other <i>(speci</i>					23d.	Date of deliver Month		ear
ecords, r	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to death bu	ut not result	ting in the un	derlying caus	se given ir	n Part I.				ontribute to th		
אוומו חפכי	ificate has be	• Completed	25. Was case referred to medical							_		y ned? 2 🗷 No	death?	osy findings as apletion of cau	vailable use of
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	ation: To Be	examiner?	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 2	R/Outpatient 28b. Time of Injury		Other: Injury at Work?	4 🗷 Nursi	ing Home	Check only one 5 Reside d. Describe ho	nce 6 🗆)	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of inju building, etc	: (Specify)						Location (Str City or Town	, State)			er,
	thin 24 hour thin 24 hour the Fune mpletely fi	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination	ledge, death on and/or inv	estigation, in	my opinic	ion, death	place, and occurred	at the time, da	ate and plac	ce, and due to	the cause(s)	
);	_	Mylnoke	MD	anth (ltana f	20a) /Tun- 15				1	DECORB	ECEN	ned (Month, E	, 201	0
	Sta	te	30. Name and address of person who con the filed (Month, Day, Year)	4) 7323 32. Registra	H ATZ	As lave		Jeki	M-1	G	REGER	seli	MARYL	Areo Di	17R
	Registra	ar	DEC 0 8 20°	10 Decem	0 1	. Spa	Kel								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 3:48A Marie Idella Bandjough Dec 3 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. (Month, Day, Year) 5-17-1926 163-22-5370 84 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3709 Singer St. 21074 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2X Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify:white Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ Charlie Dunham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Joseph Bandjough-husband 3709 Singer St., Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date any injury or 1 M Burial 2 Cremation 3 Removal from State Carrollton Church 12-7-10 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign au En Fineral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home homas E. Main St ...Westminster MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani Alzheimez disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 N No
9 Unknown 23d. Date of delivery Ectopic pregnancy Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires icate has been sig ; page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this s after death.

I Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗆 No Natural injury 5 Pending Acciden Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

349

32. Registra's Signature

ANSURIVA

DHMH 17 Rev 7/2009

the

Malwim

*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

51705

29d. Date signed (Month, Day, Year)

DR, Wastminster, MD 21157

12-03-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State	of Man		artment of I		Mental Hy	giene	10	00100
	_	State Registrar			Ce	ertificate of l	Death		Reg. Ng	1 U	38402
Physicia: Medic		1. Decedent's Name (First, Middle Laura Lou		iley				2. Date of Dea Month Dec 6	Day 2010	Year	3. Time of Death 8:15P M
Examin		4a. Facility Name (if not institution	, 0	umber)		4b. City, Town, o	r Location of Deatl		4c. Count		ו
, A		3051 Nicoden 5. Social Security Number	nus Rd.	7 1-0/10	Lun loot birthday		tminste Tif Under 24 Hrs.		Carr		1 1 101-1 5
Funeral Director		214-28-0918	1 □ M 2 🙀 F		yrs. last birthday, Yrs.	Months Days	Hours Min.	9-6-19			hplace (State or Foreign intry)
nd how at	5	Usual Residence of Decedent 10a. State 10b. County		10	Dc. City, Town or L	ocation					10d. Inside City Limits
Maryla 28a-f s	rect	MD Carr	coll			West	minster				1 ☐ Yes 2X No
with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 3051 Nicoden	nus Rd.			10f. Zip Code 21	157		10g. Citizen of USA	What Cou	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ried Armed		in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: White	
hour	olete	15. Decede (Specify only highe	nt's Education		16a. Dec	edent's Usual Occup	ation	rking	16b. Kind of E	Business I	ndustry
rithin 72 iene. r than "	Completed by	Elementary/Seconday (0-12)		(1-4 or 5+)	life.	cretary	during most or wor	King	Busine	ess	
e filed w ntal Hygi ed othe event,	as l-	17. Father's Name (First, Middle, I						me (First, Middle, i e Schaf		ne)	
mark		19a. Informant's Name/Relations			10b Mai	ing Address (Street				State Zin	Cadal
nd 2 sh satth ar n 27 is er trau		Bob Bailey-s				Nicode			-		
Page 1 and ment of Heal ant: If item ury or other		20a. Method of Disposition 1 D Burial 2 Cremation		m State		matory or other plac		Date 0 1 0	20c. Location	-	
permit. Pa Departme Importani any injury once.	1	4 Donation 5 Other (S		14	7/1 2	Carroll (ss of Facility F	letcher		al I	Home
3 8 5 8 9		23a. Part 1. Enter the disease, or	, Fact	t sourced the		254 E. N				, MD	
Eny sicia n/ Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on	Meta	statu nsequence of):	1 1	o metyru		,		Approximate Interval Between Onset and Death
Examiner	١	Sequentially list conditions,	b.	o (or as a co	onsequence or).						
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Sue t	o (or as a co	inisaquarica (1):						
physician and the burial-transit	dical Ex	resulting in death) Last	Due t	o (or as a co	nsequence of):						
icate t	edic		d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	<u> </u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e Birth 2 🗀 egnant at tim	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	sy			ate of deliv	very Day Year
uires that the signed by	2	Part II. Other significant condition	ons contributing to	death but n	ot resulting in the	underlying cause gi	ven in Part I.				the cause of death?
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cian: ertific ector,		25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec	ck only one)			
Physic this c	<u></u>	1 Yes 2 No 27. Manner of Death	1	Inpatient e of injury	2 ER/Outpatie		4	lome 5 Reside			y)
inding lath.	cate	1 Natural 5 Pendir 2 Accident Investi	gation (Mo	onth, Day, Ye		work	y at ? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
al or Atters all Directo	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 28e. Plac	ce of Injury - ding, etc. (S)		reet, factory, office		28f. Location (St City or Town		er or Rura	al Route Number,
ne Hospit in 24 hour ne Funera	Medical	29a. Certifier 1 Certifying (Check 2 Medical E only one) 3 Certifying	Physician: To the xaminer: On the b Nurse Practione	best of my lasis of exami	knowledge, death ination and/or inve t of my knowledge,	occured at the time stigation, in my opinion death occurred at the	, date and place, a on, death occurred a e time, date and pla	and due to the cau at the time, date an ace, and due to the	se(s) and manr od place, and du cause(s) and m	ue to the ca	ause(s) and manner stated.
To the with.		29b. Signature and title of certifier	Mo			estigation, in my opinic death occurred at the 29c. License	52035	2	9d. Date signe		
		30. Name and address of person	who completed ca くしく	use of death	(Item 23a) (Type, Stoner	Print)	Westmin	nster	Pec Mo 2	-1157	
State Registra		31. Date filed (Month, Day, Year)	0 8 20 10	Registra s	Signature 8.	parle	•				

DHMH 17 Rev 7/2009

Dec: Mary Bishop

(68760 Baltimore, Maryland 21215-0036

			Ple	ease Type or Pri					_		_	
			For State Registrar	State of M	larylanc		artment of I tificate of I	Health and I Death		Reg. No	2010	38403
	Physici Medi		1. Decedent's Name (First, Mid Mary	Bisho	ор				2. Date of De C.	eath 06 ^{Da}	ay 20Ĭ°Ö	3. Time of Death 9:37 A M
p. Service	Exami	ner	4a. Facility Name (if not institut	ion, give street and number) Nursing Ho	nm A		4b. City, Town, o Baltir	r Location of Death	1	40	:. County of Deat NA	
	Funeral Director		5. Social Security Number 220 – 40 – 0562	6. Sex 7. Ag	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	9. Birt	chplace (State or Foreign untry) MD
			Usual Residence of Decedent 10a. State 10b. Cour			Town or Loc	cation		104 03	, 12		10d. Inside City Limits
	farylar Ba-f sl tified	Funeral Director	MD	NA		timo						1X Yes 2 □ No
	a or 2	E D	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?
	th with ms 23 must	inera		reston Stre		140.1	212			1	USA	
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 🏝 Widowed 4 ☐ Divord	Married 1 ☐ Yes 2 ☐	Armed Forces? If 1 ☐ Yes 2 ☐ XNo If Yes, Give 1		Was Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:				14. Race - American Indian, Black, White, etc. Afr Specify: American	
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yla	ould be fill de Mental marked (marked)	잍	Dorsey C.	Myers	1			Emma		ggu		
Mai	2 shouth and the and trau		19a. Informant's Name/Relatio Marshall D	orsey-Grand	ison		-	and Number or Rui nne Roa		-		MD 21233
re,	ge 1 and 2 should be tt of Health and Men tt fitem 27 is marke or other traumatic		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of		Date		ocation - City or	
imo	Page ment cant: If		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Othe	on 3 Removal from State r (Specify)	Me		atory or other place Cremato		08-10	1		lle, MD
Balt	permit. Page 1 and 3 Department of Healf Important: If item 2 any injury or other once,		21. Signature of Funeral Service	e Licensee	,			ss of Facility W				me P.A. ,MD 21217
	Pnysician Medical Examiner	ıer	23a. Part I Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or complications that caused st only one cause on each line. a. Due to (or as Due to (or a) Due to	e. M S a conseque M C	tage.	COVOUX	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Ξ	hysic this ce al direc	은	1 Yes 2 No		ient 2 🗆 El			4 X Nursing H			Other (Speci	fy)
0 0	ding F th. After funer	cate	1 Natural 5 ☐ Pen	ding 28a. Date of inju (Month, Da		8b. Time of injury	28c, Injun work M 1 🗆	y at :? Yes 2 □ No	28d. Describe	how injun	y occurred	
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	To the To the Comp		29b. Signature and title of certif	lier .			29c. License	number		29d. Dat	te signed (Month	
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			30. Name and address of perso	n Cathus bus		3a) (Type, P	linden t	t. Bal	t,140.	7/20	1	
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		For State	tate of Marylan	d / Depa	artment of H	lealth and	Mental Hyg	jiene ^{Z U I}	0 38404	
		Registrar	<u> </u>	Cer	tificate of L	Death		Reg. No.		
Physic		Decedent's Name (First, Middle, Last)	Dorothy Cor	rine B	over		2. Date of Dea Month	th Day Year Dec 3, 2010	3. Time of Death 1:19p M	
Med Exam	dical iner	4a. Facility Name (if not institution, give street			_	Location of Deat		4c. County of De		
		8080	Solley Road			Glen	Burnie	Anne	e Arundel	
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Jul 14	Year) C	irthplace (State or Foreign ountry) Maryland	
show dat		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits	
naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show annatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Anne Arun	1 20	, TOWIT OF LOC		n Burnie			1 ★ Yes 2 □ No	
the la or 2	٥	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?	
h with	ner	8080 Solley Road				21060		U.S	S.A.	
r deat		11. Maritai Otatas	Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S _l n, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh		
Z1Z15-UU36 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Yes 2 X No f Yes, Give Year or Dates.	1	☐ Yes 2 🕱 No	Specify:		Specify:	Black	
2 hou "natu	plet	15. Decedent's Educati (Specify only highest grade co		(Give I	lent's Usual Occup kind of work done o	ation during most of wor	tking	16b. Kind of Busines	s Industry	
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filed vall Hyg	Be	17. Father's Name (First, Middle, Last)	4			18. Mother's Nar	me (First, Middle, M	Maiden Surname)		
Vial Id be Menta arkec	은	Thomas W. E	Bouyer				С	arvilla C.		
Estitimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth		19a. Informant's Name/Relationship (Type, P.	rint)		-			City or Town, State, 2	(ip Code)	
e, n and 2 Health em 2 ther t		Donna Mann 20a. Method of Disposition	Look D		262 Holmespo sition (Name of	un Drive Pas	sadena, Maryland 21122			
Saitimore, bermit. Page 1 and Department of Hea mportant: If item any injury or othe		1 X Burial 2 Cremation 3 Remo		emetery, crem	natory or other plac	i		20c. Location - City o		
IITIN	ומ	4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee			Church Cer Name and Addres		12/10/10	rasau	ena, Md.	
any any	0110	Lloyd M. E	sley				eral Service, l laltimore, Md	P. A. 21217		
-3		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death use on each line.	n. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
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sician certifi rectol	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospii	tal:		Otho	ace of Death (Chec	, ,			
Physic this eral di	e: 1	.,		28b. Time of	28c. Injury	4 U Nursing H	ome 5 X Reside 28d. Describe ho	nce 6 Other (Spe	cify)	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,	
Hospi 24 hou Funera	Medical	(Check 2 Medical Examiner: O		and/or investi	gation, in my opinio	n, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated.	
To the within Fo the сотры	Σ	only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier	-	MIOWIEUGE, O	29c. License			cause(s) and manner a 9d. Date signed (Mon		
11		Damy Schulen				7354		12/1/201	C	
11		30. Name and address of person who completed from Schulex CRN	ted cause of death (Item	23a) (Type, Pi	rint)	Pasadeno	, MD :	11132		

State

Registrar

backer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38405 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Seville Brooks Dec 2, 2010 3:00p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Carroll County Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖵 F Yrs Director 218-48-0416 Jul 15, 1948 Maryland Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural" or Items 93a or 98a.4 show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 XYes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9605 Button Buck Circle Funeral 21133 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 2 1 □Yes 2 □No Specify. Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Social Worker permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Muriel Brooks Savannah Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 Button Buck Circle Randallstown, Maryland 21133 Crystal Barrett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/08/10 Baltimore, Md. Western Star Cemetery 21. Signature of fluneral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the black, or heart black. List only one cause on each Me. Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 212: 1300 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** robable metastatic carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ∏Yes 2 ∏No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) In patient 1 ☐ Yes 2 🗷 🗸 🕽 🗆 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred LUSPICE 1 Natural 5 ☐ Pending investigation after death. I Director: A in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours after To the Funeral Dir Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

State Registrar

oward

Crossroads

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

23 32. Registrar's Signature

Saiontz

29d. Date signed (Month, Day, Year) 12/3/10

Dr. Ste #340 Owings Mills Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38406 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Bayer 2010 7:00 P M Medical Nov. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>7846 Lockwood</u> Road Dunda1k If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 F Months (Month, Day, Year) Country Director 216-34-0869 73 Yrs. 19.1937 Feb Maryland Usual Residence of Decedent show "natural", or items 23a or 28a-f shor edical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Eart: If item 27 is marked other than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Dunda1k 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7846 Lockwood Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces ò 1 Never Married 2 x Married Black, White, etc. Maryland 21215-0036 2 **TY**No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Specify h and Mental Hygiene.
It is marked other than "natural traumatic event, the Medical E White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Clerical Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Ousbourne Elizabeth Trentler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James J. Bayer (Husband) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 7846 Lockwood Road Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 $\widetilde{\mathbf{X}}$ Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11top Service Corp. 12/3/2010 Towson, Maryland Signature of Funeral Service Licenses 22 Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, _Maryland 23a. Part 1. Enter the disease, shock, or heart failure. Lie Immediate Cause (Final sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate one cause on each line. Interval Between Onset and Death Ph_sician/ disease or condition una Medical resulting in death) Due to (or as a con sequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Eunite (or as a nonsequence cry cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Year 2 X No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been signed 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page After this certificate Yes 2 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Director; / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medica 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) d ame and address of person who completed cause of death (Item 23a) (Type, Print) 11311 McCornick ramonte 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 38407

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Physic ledical Exam	ian <i>l</i> inei	Decedent's Name (First, Middle,Last)			Date of Death Month December:	Day Year	3. Time of Death 0048 hrs
			. City, Town, or Baltimore	Location of Death		4c. County of Death	\/A
Funeral Director		35	If Under 1 Year Months Day			(MM/DD/YYYY) 9. Bir	thplace (State or
	ó	Usual Residence of Decedent					
nd show any sce.	5	10a State					10d, Inside City Limits 1 Yes 2 No
he Maryland or 28a-f show ified at once.	Director	10e. Street and Number 2523 Delaney St.	10f. Zip Code 212	16	100	g. Citizen of What Cou USA	ntry?
ath with t items 23s	uneral	1 Never Married 2 Married Armed Forces? If Yes,		spanic Origin? (Sp n, Mexican, Puerto		White, etc.	ican Indian, Black,
s after de rral", or	by F	3 Widowed 4 Divorced If Yes, Give Year or Pales:	es 2 No			Africa SpecifiAmer	•
iriore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of sells than Mannal Hygienei. The most Within and Mannal Hygienei. The Triem 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	Completed		t of working life	tion (Give kind of v . DO NOT use reti		Balt. Ar	•
21215-0036 uld be filed within 77 Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle, Last) Eddie Reed		18.Mother's Name Debra		aiden Surname) Brown	
AD 21215 2 should be filt h and Mental H 27 is marked imatic event, is	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street Lauret		Rural Route Numb	per, City or Town, State	
Baltimore, MD 21215-0036 Permit Pages I and 2 should be filed within 7 Perment of Health and Mental Hygicine. Importance: Witem 27 is marked other than njury or other traumatic event, the Medica		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Bayview	on (Name of ce	metery,	Date	20c. Location - City of Balt., MD	Town, State
Baltimo permit. Page Department o Important: injury or otl		21. Signature of Funeral Service Licensee 22. Nan	me and Address	s of Facility Ha	ri P. C	Close F.S MD 21206	VS, PA
Physician		23a Part I. Intel the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	-				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Asthma Due to (or as a consequence of):					Death
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				· ·	-
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
1760, Ficate be executed g physician and sthe burial - transit		d. UNPENDED AMENDED					
3760, ificate be g physicist the buri	n/Medical	IF FEMALE: 23c If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3	Ectopic pregna	incv	23d. Date of deliver	y Day Year
Box 687 e death certification the attending red for use as t	Physician	past 12 months?	r (Specify)				,
F, P.O. I ires that the signed by the detached	á	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause (given in Part I.		2 No 3 Pro	the cause of death?
of Vital Records, P.O. Brysician: The law requires that the the certificate has been signed by meral director, page 2 should be detach	Completed				24a. Was ar autops	n 24b. Were a	utopsy findings available completion of cause of
Vital Reconstituted The lamps of the lamps o		25. Was case referred to medical	26 Place	e of Death (Check	1 Yes 2		es 2 No
Vita hysician this cert	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3		Othor:		Residence 6 Othe	er:
on of ending Pl ath. or: After he funera	tion:	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		ry at Work? Yes 2 No	28d, Describe ho	ow injury occurred	
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certificate hours after death. Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, to (Specify)	factory, office b	building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Di To the Hospital within 24 hours a withe Funeral I completely filled	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.					
5 1 × 1 0	¥	29b. Signature and title of certifier	29c. Licens			29d. Date signed (M	· · ·
_		30. Name and address of person who completed cause of death (Item 23a)	O.C.	IVÍ.⊏.		December 6, 20	
`		Ana Rubio MD. Assistant Medical Examiner 111 Penn Str	eet, Baltime	ore, MD 2120	1		
St Regist	ate trar	31 Date filed (Month, Day Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 38409 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **JOANNE BROOKS** D2010 Year 7:25 P_M DEC. 2, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) NY 8. Date of Birth 1 □ M 2 🔀 F 051-38-2444 JUN":224, 12947 63 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2 XXIVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 STONEHENGE CIRCLE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACTIVITIES DIRECTOR NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAUL MILLER ANNA BARRON 19a. Informant's Name/Relationship (Type, Print)
MARTIN BROOKS/ HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 STONEHENGE CIRCLE #17; BALTIMORE, MD 21208 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BNAI ISRAEL 12/5/2010 BALTIMORE, MD 21. Signature of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final yens

Physician/ Medical **Examiner** by the attending physician and stached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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ıral", or items 23a o Examiner must be

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permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meany injury or other traumatic event, the Me

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Completed

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72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Medical Certificate: To Be Completed by

29b. Signature and title of certifie

ate has been signed by the a page 2 should be detached to

eral Director: After this certific filled in by the funeral director,

within 24 hours after To the Funeral Direc

Division of Vital Records, P.O. Box 68760

1	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):		
Cause (Disease or iinjury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Check		
1 🗆 Yes 2 No	Hospital: Cthor:		6 Other (Specify) WAR IN
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) n	8d. Describe how inju	
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	nd Number or Rural Route Number, e)	
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place	and due to the cause(s) and manner stated

License number

29d. Date signed (Month, Day, Year)

2010

Registrar HMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are/Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month CROCETTT a^{M} VELMA Α. 11:00 December 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Ever Care Hospice 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗷 F Months Days Hours Min. Feb 6, 1922 217-12-6195 Country) Marvland 88 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 600 Light Street, Apt. 633 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify: If Yes Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Clerk Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Albert Hundertmark Marie Bagnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Light St., Apt. 633 Baltimore. Maryland 21230 Ector T. Crocetti (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bayview Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/8/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fuseral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician/ Medical Examiner

attending physician for use as the buria

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certificate has page

24 hours after death.

Personal Director: After the furth of the furth

the Hospital or Attending Physician: The

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Director

Funeral

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Examiner

Funeral

Director

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r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

al Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event,

Should be file and Mental F

Baltimore, Maryland 21215-0036

Be Completed by

(Check

only on

James N. Tansinda M.D.

Date filed (Month, Day, Year)
DEC 0 8 2010

29b. Signa

shock, or heart failure. List only one Immediate Cause (Final disease or condition	a METASTATIC BREAST	CANO	Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of):	•	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of).		
resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.		ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)	,
1 L Yes 2 LE No		Home 5 Residence	6 L Other (Specify) Hospice
27. Man er of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge, death occured at the time, date and place,	and due to the cause(s)	and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3455 Wilkens Avenue Suite 204, Baltimore, Maryland 21229

DO056948

29d. Date signed (Month, Day, Year)

DEC 2²2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar ATTENDINS

32. Registray's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me,g910,12/08/2010dhb
Certificate of Death
Rec. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0725AM Medical 44. Facility Name (if pot institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ante Carrol1 Westminster If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year
Aug 25, 1 9. Birthplace (State or Foreign Funeral Days 180M 2□F Months Hours Country) Maryland Director 215-28-5323 80 Ĩ′930 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 244 Parkholme Circle 21136 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2x No Examiner Black White etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: White "natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Head of Purchasing J. Schoeneman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Czapski Hedwig Wojtysiak other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Gertrude Czapski 244 Parkholme Circle Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-2-2010 St Stanislaus Cem Dundalk, Maryland 22. Name and Address of Facility 11824 Reisterstown Road Sig at r f Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Ut danying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): the attending physician the for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. **To the Funeral Director**: After this certificate has I autopsy performed? death? completed filled in by the funeral director, page 25. Was case referred to redical examiner? 2 1 Yes Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29c. License number 29d. Date signed (Month. Dav. Year) 2010 s of person who completed cause of death (Item 23a) (Type, Print) 200 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$16b of Maryland 10 partment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death esse **Physician** 10:52 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 052-24-9238 79 **Director** 2-17-1931 N V Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 1 XYes 2 □ No MD Director na Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7047 MCClean Blvd 21234 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iter Examiner Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examiner 1 X Yes 2 If Yes, Give Year or Dates; 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>\$</u> Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US Navy r than " Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie Croxton, Sr ρ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 7153 McClean Blvd Balto, MD 21234 Rosalind B. Jackson-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12-14-10 Owings East F/H Mills, MD 21. Signature of F of Funeral Service Licensee 22. Name and Address of Facility March Mullin 1101 E. North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Subdural Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner subarachnoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed ng physician and e as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ± 280 Division of Vital Records, P.O. Box 68760, Physician/Medical OF RITH CATION IF FEMALE: nse 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; this certificate has 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 1 Inpatient 2 🗌 No 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred

found at the bottom of Stairs

10-12 Steps

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident Injury 5 Pending investigation evening 2 No 1 🗌 Yes 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 7047 McClean Blvd, Balt, MD21234 home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 2,2010 10.41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron LackampmD 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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Baltimore, MI permit. Pages i and 2 s Important of Health a Important: Iften 27 injury or other traum.	20a. Method of Dispos	sition Cremation 3 Removal from St	20b. Place of [Disposition (No or other place	lame of cemetery	Date Date	20c.	Location - City or	Town, State
Baltimore, pernit. Pages I ar Department of Hee Important: If ite injury or other tr	4 Donation 5	Other Specify:	Metro	Crem	atory	12/11/2	2010	Catonsv	ille,Md.
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Physician / Medical	23a, Part / Enter the d	disease, or complications that caused one cause on each line.	the death. Do not e	enter the mod	e of dying, such a	as cardiac or respirato	ry arrest, she	ock, or heart	Approximate Interval Between Onset and
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fur	29a. Certifier (Check only 1 Cer	rtifying Physician: To the best of my	knowledge, death	occurred at th	ne time, date and	place, and due to the	cause(s) and	d manner as state	d.
To the Ho within 24 To the Fu complete!	29b. Signature and title	adical Examiner: On the basis of examiner and manner stated.	nination and/or inve		ny opinion, death 9c. License numb			ce, and due to the Date signed (Moni	
	Auch	16	7 1	10	O.C.M.E.			ember 2, 201	
	30. Name and address of Russell Alexan	of person who completed cause of dender MD. Assistant Medica	'	111 Penn	Street Raltin	more, MD 21201			
State	31. Date filed (Month, D	Pay Year 1010	e Signature A	plan .					
Registrar	חבל ל	o colo farma	E. Year	1000				OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CARSON KATHLEEN 05 = 46 AM NOVEMBER 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPItal Baltimore Baldnore Harbor If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinar must be notified at Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral Director

npleted by

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Be Cor	17. Father's Name (First, Middle, Las	(1)	7,55		ame (First, Middle, Ma.	den Surname)	
20	Roy Smith			M	61 60	ricon	
	19a. Inform t's Name/Relationship	(Type. Print)	19b. Mailing Add	ress (Street and Number or .	Jural Boute Number, C	ity or Town, State,	Zip Code)
	Karen Moore	Parahter	1802 1	Attle Rel L	Flen Buri	ne MI	21061
	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	Place of Disposition demetery, crematory	or other place)	27/10 1	c. Location - City of	Town, State
	21. Signature of Funeral Service Lice	ensee	226	e and Address of Facility	chrock-Hog	an FH	15022
	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Congestive	heart to	mode of dying, such as cardi	ac or espiratory arrest	, , , , , ,	Approximate Interval Between Onset and Death
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	Cause. Enter Underlying Cause (Disease or injury that initiated events	C					
	resulting in death) Last	Due to (or as a consequ	uence of):				
Due to (or as a consequence of): Due to (or as a consequence of):							
	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlyir	g cause given in Part I	23e. Did tohac	co use contribute to	the cause of death?
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1	25. Was case referred to medical			OC Place of D	1 ☐ Yes 2 ☐ eath (Check only one)	No 1 ∐Yes	2 1 No
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Ī	27. Manper of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence		icity)
	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, street, fac	ory, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
	29a. Certifier (Check only one)	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	vledge, death occur ion and/or investigat	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mont	h, Day, Year)
		esident-P64-1		les -001	No	I OMBER 2	2 2010.
1	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	3001 South		eet	

DHMH 17 Rev 1/2001

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Registrar

Abera

31. Date filed (Month, Day, Year)

Registrar's Signatur

Baltmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12-03-2010 Amelia S. Carlos 1832 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11-28-1931 3 1 M 2 X F Davs Hours Min. Philipines Director 214-78-4612 79 Usual Residence of Decedent th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1149 Sparrow Mill Way 21015 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Asian 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fil. Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evence. Leonilo Simpao Cristeta Tugade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perlita Chin (daughter) 1149 Sparrow Mill Way Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 12-08-2010 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Meumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 2 - No page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? , Amelia Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No 1 Tes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2. No မှ 1 🗌 Yes 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1 Natural 5 Pendina within 24 hours after death. To the Funeral Director; A 2 Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 0069415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) packe Dr. Belair, md 21014 Edward 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Registrar
DHMH 17 Rev 7/2009

State

racke

D 0062704

3290 N. Ridge Rd. Swite 100 Ellight Gity

PHYSICIAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

KARTIK J. DESAI

2010

31. Date filed (Month, Day, Year)

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The State of the Control of the Cont	1											
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEANNE NUNEZ, MD 4940 Eastern Avenue, Boultimore MD 21224		To To Con	2	29b. Signature and title of certifier	, nd				1_	_		
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JEANNE NUNEZ MD 4940 tostern Avenue, Baltimore MD 21224						em 23a) (Type, I	Print)		0 11		,	
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Registrar

DEC 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 5, 2010 Josephine 4:57 AMM Engle Duncan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ Months May 29, Year) 923 West Virginia 233-30-6239 87 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director North Potomac 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14516 Kings Grant Street 20878 USA items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. ò 1 Never Married 2 Married Yes 2 No þ Maryland 21215-0036 72 hours after If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural" 3₺ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Representative Telephone Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ora B. Rider Aldon W. Engle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14516 Kings Grant Street, North Potomac, MD Barbara Wlocarczak -Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 12-10-2010 4 Donation 5 Other (Specify) Sutton, WV Sutton Cemetery Sunavire of Funeral Service Licenses Hastings Funeral Home 22. Name and Address of Facility 26505 153 Spruce Street, Morgantown, WV $\delta_{
m ort} h$. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death mmediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last and -trar Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2X No has certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 2 🔀 No Hospice 1 Inpatient 2 ER/Outpatient 3 IDOA ည 124 hours after death.

E Funeral Director: After this leted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending 1 X Natural 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 12-05-2010 R120698 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Nicole Christenson

Jacke.

CRNP

Registrar's Signature

6001 Muncaster Mill Road, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g910 12/8/10 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Physician/ DEC. 4:35PM Medical GEANE MOORE DANIEKER 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 4300 Cardwell Ave. Apt. Baltimore County 8. Date of Birth April 26, 1926 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 . M 2XXF Marvland 214-20-9071 84 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🛛 No Baltimore County Marvland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21236 4300 Cardwell Ave. Apt. 329 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3xx Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) 12 yrs. Housekeeping-Own Home Housewife and Mental Hygie is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental h.
Important: If item 27 is marked any injury or other. Amanda Luwinzia Barnes ည Charles Robert Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Danny M. Daneker 506 Applewood Dr. Belair, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 12-9-2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7401 Belair Rd. at re of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Balto., Md. 21236 100Atrou or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ovas Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** perter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or se consequence of) Examir Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant
9 ☐ Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b cate has I page 2 s autopsy performed stanemia ara 1 ☐ Yes 2 ☐ No Yes 22 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kama . 9512 N. Harford Road 212 Parkville, MD 21234 shalini 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 6 2010 Physician Ida M. Davis 10:45am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Woods Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 5 1925 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Baltimore City.MD 217 18 9403 85 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Baltimore Baltimore County Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If then 27 is marked other than "nature." any injury or other traumating any injury or other traumating and injury or other t 21234 3301 Upton Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Signorelli Valentine DellaPietta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Presway Road Timonium, Maryland 21093 Janice Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Metro Crematory December 7 2010 Baltimore Maryland 4 □ Donation atire of Funeral Seprice Licenses 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALZHEIMERS -STAGE END **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUFFICIENC 1 Tyes 2 ☐NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No after death.

i Director: A
d in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of cortifie 29d. Date signed (Month, Day, Year) D40008

State Registrar DHMH 17 Rev 1/2001

8

SQUARE

FRANKLIN

DR

BALTIMORE, MD

2125

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9105

32. Registrar's Signature

PARSHALL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08:41 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner MA timore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 05-26-1 X M 2 □ F 245-14-1682 91 Yrs. **Director** SC Sr. Duker, Les Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland **Funeral Director** or 28a-f 1 ¥ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a permit. Page 1 and 2 should be filed within 72 hours after death with 3509 Holmes Avenue 21217 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Xves 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Arrican ,0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: WWII Specify: American "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Menones. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade ÑΑ Used Car Dealer Owner of Dealership Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Robert Duren Janie Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Holmes Avenue Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Mamie Duren-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12-13-10 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Street Baltimore, MD 21217 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End disease or condition Due to (or as a consequent of) Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 12 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🗷 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 12/02/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7900 MROW

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 Eugene Charles DeCarlo 6:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 6533 Baltimore Avenue N/A If Under 1 Year I If Under 24 Hrs.

Months Days Hours Min. . Sex 1 M 2 □ F 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Mary land June, of 0, 1925 85 Director 219-18-9609 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Yes 2 No N/A Baltimore Marvland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21222 United States of America 6533 Baltimore Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 1943-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Crown, Cork, & Seal Machinist 11th Grade Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Donetelli Eugene DeCarlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216 Woodhome Avenue/Baltimore, Maryland 21234 Deborah A. DeCarlo/ Daughter 20a. Method of Disposition

1

□ Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Moreland MemorialPark Dec.7,2010 Baltimore, Maryland 21, Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 5305 Harford Road eonard J. Ruck Funeral Home Baltimore, Md. 21214 Usandra Sta 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 10 70 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** la Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending ithin 24 hours after death.

o the Funeral Director: After ompleted filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier migr-0 03186 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 Baltimore 206 anten s

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

N.

●32. Registrar's Signature

10

0-09187 elena Delvecchio		Please Type or Print in Black Indelible Ink. Ensure All C State of Maryland / Department of Health and Ment	copies Are tal Hygien	e Leg ik e	ole.	38423					
	R	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	2. Date	Reg. It		3. Time of Death					
Physician Medical Examine		Calina Mania Dalyacahia	Mont		y Year), 2010 4c. County of Death	0905 hrs					
	ľ	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Baltimore	4b. City, Town, or Location of Death Baltimore								
Funeral Director		216-96-9714 1 M 2 F 32 Yrs. Months Days Hours				thplace (State or on Call Tornia untry)					
nd thow any <u>ce.</u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore				10d. Inside City Limits 1 X Yes 2 No					
the Maryland a or 28a-f show	Ulrector	10e. Street and Number 6421 Marietta Avenue 10f. Zip Code 21214		10g.	Citizen of What Cou USA	ntry?					
death with	runeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 No Specify Cuban, Mexican, 12 No Specify Cuban, Mexican, 14 No Specify Cuban, Mexican, 15 No Specify Cuban, Mexican, 16 No Specify Cuban, Mexican, 17 No Specify Cuban, Mexican, 17 No Specify Cuban, Mexican, 18 No Specify Cuban, Mexican, 19 No Specify Cuban, 19 No Specify Cub	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:			14. Race - American Indian, Black, White, etc. White Specify:					
5-0036 led within 72 hours after ffygiene. other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Unemployed	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired) Inemployed			Industry					
5-00 led with Hygiene other			's Name (First, M		len Surname)						
MD 21215-0036 d 2 should be filed within 7 and Mental Hygiene. n 27 is marked other than matice event, the Medical	9 0 0										
re, s I an f Hea If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.	Date 12/2/10		oc. Location - City or Towson Mary						
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 23. Name and Address of Facility 3305 Hartford Road				Approximate Interval					
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alprazolam and alcohol intoxication Due to (or as a consequence of):									
1/2 - 1	m me	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
execul	ᇹᅡ		/11/ TT		23d. Date of deliver						
OX 68 eath certification in the sate of th	sician/	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 past 12 months? 23d. Date of delivery Month Day 23d. Date of delivery 1 Ves 2 No 9 V Unknown 23d. Date of delivery Month Day 25d. Visually 1 Pregnant at time of death 5 Other (Specify) 27d. Date of delivery 27d. Date of delive									
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Division of Vital Records, P as or attending Physician: The law requires t rs after death. The Third continues of the continue of the continu	Completed			a. Was an autopsy performe Yes 2	prior to death?	utopsy findings available completion of cause of es 2 No					
Vital Reorgysician: The his certificate director, page	å	25. Was case referred to medical examiner? Hospital:	(Check only one Nursing Home		sidence 6 🗸 Othe	ar: Scene					
n of Viding Physical After this	의	27 Manager of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work	28d De sub	scribe how	injury occurred ingested	alprazolam					
Divisior ital or Attend urs after death. ral Director:	Certification:	Pending Investigation Fd 11/30/10 Fd 9:00 am 1 Yes 2 2 No and alcohol and alcohol 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5903 Theodore Ave. Baltimore, MD									
Div To the Hospital o within 24 hours af To the Funeral D	edical										
, ,	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) December 1, 2010					
ϕ		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 212	01							
Sta Registr	te										

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ lauid Javy Month dov 0045 Decemb 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 02/10/1924 86 RUSSIA Director 050-84-5369 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 4204 OLD MILFORD MILL ROAD USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates WHITE Completed 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) UNK UNKNOWN UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental | 27 is marked of traumatic eve 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic conce. UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWSON BALTO DEPT OF AGING, 611 CENTRAL AVE, #301, MD 21204 YALANDA DORCEY/GUARDIAN 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM : 12/7/2010 BALTIMORE, MD Signature of Juneral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or illipury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier December 6, 2010 D37573

State Registrar 21209

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vadis

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year tranklin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Baltimore orthopint If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **M** M 2 □ F Jan. 9ay, Year 20 Days Hours 90 **Director** 212-22-4920 Yrs Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 ★ Yes 2 □ No MD N/A Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 21213 <u>2406 East Hoffman Street</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Dever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates. 3 M Widowed 4 □ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Unknown Sparrows Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H If item 27 is marked ot ir other traumatic ever မ Mildred Douglas Lazarus English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. 4116 Eierman Avenue Baltimore, Maryland 21206 Anthony English - Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Crownsville Maryland 4 Donation 5 Other (Specify) Crownsville Veterans Cem. 12/3/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thatman-Harris Funeral Home Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): **Examiner** gangrene Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dementa WA HTN) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 Ø No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 😿 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day tvans La: ZOAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Month, Day 58 Country) Director MD Usual Residence of Decedent 28a-f shov be filed within 72 hours after death with the Maryland ental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified Battimore atonsvIIIe 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Country Mill 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Coilege (1-4 or 5+) Clerk Human 12th grade year Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hilmportant: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Mill Court Evains Husband Catonsville MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Onings Milks, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 Jamisor Vaughor C. Gireens Funeral Sowices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility allstown LDa 23a, Part 1, Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart falure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ō Month Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tyes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 👃 📗 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angeline Ellen Edison Year 1508 M Medical ember 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u>Union Memorial</u> Hospital <u>Baltimore</u> Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2x F Days Months 220-54-9439 Hours 8-12-1950 Country) Director 60 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showing any injury or other traumatic event, the Medical Examples. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 No na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 W. 20th Street Apt 14 F USA 21218 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Spec.Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Internat 10th grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Otis W. Thomas Lucy Oliver Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Lester Thomas-Son 20th Street Apt 14 F Balto, MD ll W. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12 7-2010 Greenmount Balto, MD 21202 Signature of runeral Service Licensee 22. Name and Address of Facility March East F/H 1101 Balto, E. North Avenue MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death chaestive disease or condition Medical resulting in death) Due to (or as a consciuence of): **Examiner** upertensic Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year the Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Onknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 🗌 No 1 Yes 25. Was case referred to medica B B 26. Place of Death (Check only one) 2 🗹 No Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗆 Yes 2 🗆 No 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053539 2010 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI Union Memeria Bultimore inton 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 5. IRWIN **EAGLE** 2010 5:03 PM Medical 4a. Facility Name (if not institution, give street and number)
Greater Baltimore Medical Examiner 4b. City, Town, or Location of Death
TOWSON 4c. County of Death Center Baltimore 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs, last birthday, If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 1√2 M 2 □ F Months Days Hours 130-22-7344 0376171931 **Director** 79 NY Usual Residence of Decedent 28a-f shov death with the Maryland items 23a or 28a-f sho er must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE OWINGS MILLS 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 BERRY VINE DRIVE 21117 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give 5 ò 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify: "natural", 3 Divorced 4 Divorced Completed Specify. Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER FABRICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARRY EAGLE SARAH LEVINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDIA EAGLE/WIFE 201 BERRY VINE DRIVE, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Denation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM. 12/7/2010 BALTIMORE, MD Lignature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of) Examiner 010010 intu Sequentially list conditions cause (Disease or linjury Due to (or de a concequence of, physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year detached 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 20909 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hathe m 701 marie Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert William Fri	1	- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		Mental H	_	eg. No.	10	3842	9
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d		203 Beech Lane			İ	Stevensville	.coductive Doduct		Queen A			
Funeral	7	5. Social Security Number	6. Sex	7. Age (în yrs. I	last birthday)	If Under 1 Year	If Under 24Hrs	_	th (MM/DD/YYYY)		lace (State or Fore	ign
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Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country	17	
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Baltimore, MD 21215-0036 Bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation		rom State	crematory or other	ner place)				•		
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760, ficate be g physici the buri		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes,	outcome of preg			75-ti		23d. Date of c	-	V	7
Box 6876 The death certificate the attending physe of for use as the	Clar	past 12 months?	4 Pregr	ointn nant at time of de	noth -	taIdeath 3 <u> </u> ner <i>(Specify)</i>	Ectopic pregna	ncy	Month	Day	Year	
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Registra	ar_	<u>DEC U 8 2010 .</u>	My company	1 100	arks!							_

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LOYENCO Monti . 50 M Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MD 2/23 Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Dec. 20 pay 1920 219-22-7465 Director 89 Mary Yand Usual Residence of Decedent Fshow 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☑ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2421 Woodbrook Avenue 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced 4 Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Silk Finisher Years Star Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Fallin Cora Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin B. Roberson - Daughter 3129 Normount Avenue Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/11/2010 Woodlawn Cemetery Woodlawn, Maryland Signature of all Service License 22. Name and Address of Facility Chatmen-Harris Funeral Home any 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ce of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month 9 Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No 24a. Was an autopsy erforn 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 2 No မ 1 🗌 Yes Other: ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu of certifier person who complete cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month,

Day,

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32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, DEC 0 8 2010

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITVL DAVIT GOSS CHEVICLE ANVE 32. Registrar's Signature parke

and manner stated.

M.D.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38432 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Month 8:45P 20 10 Mary Rita Fraim Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3 Locust Path Ct. Nottingham Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months 1(Month, Pay, 1 Pag) 1 Director 214-14-4796 88 Yrs Maryland Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Maryland Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Locust Path Ct. 21236 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 yrs College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Dietrich Marv Schnedler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Fraim son 9700 Magledt Rd. Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Holy Cross Cemetery 12-06-2010 | Baltimore, Md. 21. Signature of Funeral Service Licensee 22 Schimader of Talleral Home, Inc. 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Lailnra Inset and Death Physician/ disease or condition resulting in death) Weeks Medical Due to (or as a consequence of): Examiner perter Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year signed by the a 1 ☐ Yes 2 ₽ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been si rector, page 2 should 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ After this 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed (Check only one the the

Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

and the start of

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ahadar Mameni, mo 8601 Veterans Hwy #211 Millersville, mo

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050254

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38433 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30, Dorothy 2010 В. Fennel1 Nov. 11:55A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Northpoint Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2√□ F Hours 94 **Director** 214-38-2597 April 10,1916 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examination to the profiled. Director MD Baltimore Co. Baltimore Co. 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7603 Poplar Avenue Funeral 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3√Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Schools of Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Teacher Baltimore County 2 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Sweat Archibald Bourdon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nena Woodin (Daughter) 7603 Poplar Ave. Baltimore, Maryland 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/3/2010 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc., 7922 Wise Ave. Dundalk, Maryland, 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 234. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failue holi'c **Physician** S /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off attending physician and for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No signed by the a o 9 I Inknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death

Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated

within 24 hours aft

To the Funeral Di

completely filled in the V

> State Registrar

29b. Signature and title of certifier

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32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 69540

29d. Date signed (Month, Day, Year)

words Rd Suite 204 Parkville MD 21234.

12/01/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Dec 3, 2010 Georgia Nell Ferree 8:43 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 334 Community Rd Severna Park Anne Arundel 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗙 🕱 Months Days Hours Min Director 82 457.40.4745 Sept 21, 1928 ΤX Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 □ Yes 2 🗓 🐧 o MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 334 Community Rd 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Giv XX Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₩idowed 4 Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Truman Gordon 2 Nellie Mary Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ahmed 1259 Tamarack Tr, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ Burial 2 ☐ Cremation 3 K Removal from State Strawn\Cemetery Strawn , TX 4 ☐ Donation 5 ☐ Other (Specify) 12.7.2010 22. Name and Address of Facility Fink Funeral Home, P.A. 21. Signature of Funeral Service L K) Gregory Fin MO1148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician UNG /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (clisase or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buriz Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month signed by the a d be detached fo Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ s peen s 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2 s autopsy perform 1 □ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Certification: To 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

29b. Signature

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and ad Ir and the erson who completed cause of death (Item 23a) (Type, Print)

JASON TAKSEY, M.D.2003 MEDICAL PARKWAY WAYSON PAVILLION SUITE 210 ANNAPOLIS, MD 21401

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year CIAILING Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Month, Day Year) pr. 22, 1922 1 M 2 F Days Hours Min 577-20-7260 Director Washington, D.C. 88 Apr. Usual Residence of Decedent or 28a-f shov Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Churchton MD Anne Arundel 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5703 Broadwater Parkway 20733 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 √ No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Ricker Helen Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Miller/Daughter 5703 Broadwater Parkway, Churchton, MD 20733 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 30 cemetery crematory or other place) Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service L 22. Name and Address of Facility Columbia Mortuary Services, P.A. Wo /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each rie. Approximate Interval Between Opcetyand Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to for as a consequence of Examiner con if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year signed by the at d be detached for Pregnant at time of death Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown plnous peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy perforn 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 24 hours after death. Funeral Director: A 1 🗆 Yes 2 No Accident Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of ertifie 29c. License numbe

Registrar

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person who completed dayse of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death Date of Death 3. Time of Death Physician/ Medical Name (if not institu on, give street and n **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 8. Date of Birth (Month, Day, Ye Sept. 4, **Funeral** Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 XM 2 - F Hours **Director** 172-28-1278 77 Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Dunda1k 1 🗆 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8243 Del Haven Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Korean 1 x Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 🙀 Married Black, White, etc. "natural", or ģ Yes, Give Maryland 21215-0036 1 ☐ Yes 24 ☐ No Specify: Completed 3 Widowed 4 Divorced Year or Dates.1953-56 White f Heath and Mental Hygene.
item 27 is marked other than "natul
other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Factory Worker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Schardt Roy Geiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8243 Del Haven Road Dundalk, Maryland 21222 Mrs. Mary M. Geiger (Wife) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial_2 Cremation 3 Removal from State cemetery, crematory or other place) Stanislaus Cemetery 12/7/2010 4 Donation 5√☐ Other (Specify) Baltimore, Maryland Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one conservations are such as cardiac or respiratory arrest, shock, or heart failure. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate Physician/Medical Examiner cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (br as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 🗌 Yes 2 4 1 Inpatient ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certified X 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 FREDERICK ADAM HESS 6 40 AM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square FRANKLIN Baltimore Rosedale HOSPITal 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 🗆 F (Month, Day, une 22 Min. Hours Director 92 Yrs. Maryland 217-03-5609 June Usual Residence of Deceden show or 28a-f show notified at Ob. County Baltimore 10a. State Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore County 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 8810 Walther Blvd. Apt. 1512 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes XX No Specify Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 yrs. <u>N</u>/A Crew Supervisor B.G. & E. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Hess Barbare Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey S. Hess (Son) 101 Upnor Rd. Baltimore, Md. 21212 Baltimore, 20a. Method of Disposition 65 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-11-2010 Ch. Cem. Fullerton. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Lassahn Funeral Home Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Edema Pulmonary disease or condition Medical resulting in death) Examiner nearT ongestive Sequentially list conditions, if any mading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events mitral reguraitation resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown signed by the a Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≧ stage renal disease Completed 1 Yes 2 No 3 Probably 4 Onknown been ATrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autops performed?

Yes 2 No nis certificate h I director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an tle of certifier 29d. Date signed (Month, Day, Year) 12-7-10 H69248 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Carrie Samiec 9000 FRANKLIN Square DR Balto md 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

Amend Items 25tate of Maryland Department of Beath and Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jacquelene rance HIGUS 6 910 2016 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death yrsp.190 County Creneral Columbia MI HOW ARD **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔯 F Year) 928 Months Hours May 10 Min Director South Carolina 215-24-9264 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f 1 ☐ Yes 2 X No MD Howard Ellicott City ō 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a o Funeral Apt 321 3020 N. Ridge Road 21043 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🕱 No Specify: White 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Completed 3 - Widowed 4 - Divorced Year or Dates Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Hair Dresser Beauty Be 17. Father's Name (First, Middle, Last) ont of Health and Mental Hy it if item 27 is marked oth y or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Ab Travis Goodale Jewell H. Streater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Goodale Nephew 623 Aldershot Road; Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Meadowridge Mem.Park 11/11/2010 Elkridge, MD 1 D Burial 2 Cremation 3 Removal from State Department Important; If any injury or 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licental complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Corde myopa/4 Physician/ 1 Schemic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. CERTIFICATION APPROJED BY MEDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 23e. Did tobacco use contribute to the cause of death? is certificate has been sidirector, page 2 should? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of o 28a. Date of injury (Month, Day, Year) 28b. Time 7:00 Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Division work 1 Tyes accounted fall. at he apartment Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town (Site) 3004 North Light determined North Rider 2104 Sapt. home EllicottCity MD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier D30641 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Mick Road Sabapalmi Back 201-109 31. Date filed (Month, Day, Year) 32. Registrar's Signature State EC 0 8 20 ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Day Day December Physician/ Year 201 6:36 RM 5, Dorothy Louise Hall 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1651 Heathfield Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Days Months Min. Hours Month, Day Dec 30 Year) 1921 Country) Maryland 88 Director Yrs 216-18-7373 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1651 Heathfield Road 21239 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ ▼ o
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: Completed 3 Nidowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Eugene Owens Mabel J. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Gray /Daughter 2622 Nemo Court Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dec 09 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee M01442 22. Name and Address of Facility

Cremation and Funeral Alternatives <u>8717 Green</u> Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (of as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atter edetached for u in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown vate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 🗆 Yes 2 🗆 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation Could not be

Division of Vital Records, P.O. Box 68760 after death.

Director: After this certificate | filled in by Hospital within 24 hours a

Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pr only one nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 23a) (Type, Print) MD 32. Registrar's Signature

State Registrar

			Please	State of Marylar	nd / Dep	partment of h	Health an	-		_	38440
		_	Registrar 1. Decedent's Name (First, Middle, L	act)	<i>Ce</i>	ertificate of	Death	2. Date of D	Reg. No.	2010	3. Time of Death
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	/Medi Examii		4a. Facility Name (If not institution, g	IVERSIDE		4b. City, Town, o	CAM	Death D	4c.	County of Death	ed
fi	Funeral Director		5. Social Security Number 215-01-4944 Usual Residence of Decedent	Sex 7. Age (in yrs. 1 ☐ M 2 ☐ F 90	Yrs.	Months Days		Mrs. 8. Date of Bi Min. (Month, D April		COL	place (State or Foreign intry) yland
	e Maryland 3a-f show Illied at	Director	10a. State 10b. County Md. Harf		ty, Town or L						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercities must be retified at sonce.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes M No If Yes, Give Year or Dates:	.S. 13	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🏋 No		g? (Specify Yes or N euerto Rican, etc.)		14. Race - Amer Black, White,	
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Maryland	d 2 should th and Mo 27 is mark traumati	욘	19a. Informant's Name/Relationship Steven M. Hutch			ling Address (Street	and Number o	or Rural Route Num	ber, City o		ip Code)
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Baltimore,	Page tment tant: If jury or		1 to Burial 2 □ Cremation 3 to 4 □ Donation 5 □ Other (Spec	ify) Ga	rdens	of Faith	12	-6-2010	Balt	to. Md.	
Ball	permit Depar Impor any In		21. Signature of Funeral Service Lice	ensee	1	22. Name and Addre 9705 Bela	ess of Facility	Schimunek d Nottin	Fune	eral Hom	236
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-24			Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age fin yrs. Jas.		Baltim		1		<u> </u>	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las: 1 \(\time \text{XM} \) 2 \(\time \text{F} \) 7. Age (In yrs. las: 92	' birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. Min.	8. Date of Birth Month, Day, 12/31/		9. Birthp Count	lace (State or Foreign try) MD
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Baltimore, Maryland 21215-0036	permit, Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee								Burnie, MD
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<u></u>	ian: ertificz ctor, p		25. Was case referred to medical examiner?		26. Plac	ce of Death	(Check		93 110	10 163 2	
5	hysic his ce	욘	1 Yes 2 No Hospital: 1 Inpatient 2 EF		3 DOA Other	4 🗌 Nurs	ing Hom	ne 5 🗌 Reside	nce 6 🗆 Othe	er (Specify)	
סר	ling P	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	b. Time of injury	28c. Injury a work?			Bd. Describe hov	v injury occurre	ed	
Sior	ttend death stor: /	tilie	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home	farm etro		′es 2□N		0/ 1 1/ /0/			
Division of Vital Records, P.O.	after after bin bin bin bin bin bin bin bin bin bin		4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, 141111, 3110	et, lactory, office		2	8f. Location (Str. City or Town,		er or Hurai i	Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dath. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1. Certifying Physician: To the best of my knowledge	ge, death o	ocured at the time, o	date and pla	ace, and	due to the caus	e(s) and manne	er as stated	
	tin 24 hin 24 he Fu hplete	Mec	(Check 2 Medical Examiner: On the basis of examination aronly one) 3 Certifying Nurse Practioner: To the best of my kr	id/or investi lowledge, de	gation, in my opinion eath occurred at the t	, death occu time, date ar	irred at ti nd place,	he time, date and and due to the o	place, and due ause(s) and ma	e to the caus inner as stat	se(s) and manner stated. ted.
	North To To To To To To To To To To To To To		29b. Signature and title of certifier	40	29c. License r				d. Date signed		
			Minney 1-0	- 'J'		13894	6	l	recemb	08/	6,2010
			30. Name and address of person who completed cause of death (Item 23			44 -	2	1721			
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 - 0	facel	MI)	4	23/			
	Registra		DEC 0 8 2010 Cenura	B. A	Jak						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHNSON Wenth December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OWERD LOUNTY GENERAL Hospita CoLumbia 40WARD **Funeral** Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Hours Director Usual Residence of Decedent 28a-f shov 10a, State filed within 72 hours after death with the Maryland 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMOR Yes 2 🗆 No ò 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral U.S.A. 21229 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry

5 TATE OF MARWANA (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) UNEmployment OFFICE OFFICE WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve L. ALLEN SR. THOMAS ElsiE Estelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAR ORIE 20a. Method of Disposition HOLMES/DAUghter MAR Baltimore, 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 110/2010 4 Donation 5 Other (Specify) NE PK, CEME. 10 2010 BALTIMORE MARY AND 22. Name and Address of Facility The DERRICK C. 3003 Jones FH 21. Signature of Funeral Service Libensee 4611 Park Heights Ave. Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) psis WI Medical Due to (or s a consequence of Examiner 20 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed сотрыет filled in by the funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After t 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No within 24 hours after deal To the Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 30 64 2010 Docember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Romesh Sabapathi 201-109 Back River Neck Load Baltimore Marylow 2124

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Ctata	partment of Health and Nertificate of Death		ene g. No.2 0 1 0	38443
	Physicia Medi		Decedent's Name (First, Middle, Last) CARROLL EDWARD JAEGER		2. Date of Death Month DEC.		3. Time of Death 3:40PM ^M
	Examir		4a. Facility Name (if not institution, give street and number) GILCHRIST CENTER	4b. City, Town, or Location of Death TOWSON	DLU.	4c. County of Death	
	Funeral Director		5. Social Security Number 214-16-8603 6. Sex 1XXM 2 □ F 95 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) April 22	(ear) 9. Birthp (County) 9. Birthp (County) 9. Birthp	place (State or Foreign try) yland
	aryland a-f show fied at	Director	Usual Residence of Decedent	ocation altimore County		1	I0d. Inside City Limits 1 ☐ Yes 2★ No
	vith the Mi 23a or 28 st be noti	eral Dire	10e. Street and Number	10f. Zip Code 21234	10	g. Citizen of What Cour	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2 □ No If Yes, Give Year or Dates. WW 11	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
Maryland 21215-0036	ithin 72 houn ene. r than "natur the Medical I	Be Completed by	15. Decedent's Education (Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng	6b. Kind of Business Inc	dustry
/land 2	d be filed w Wental Hygi arked other artic event,	To Be	17. Father's Name (First, Middle, Last) Ernest Jaeger	or Finisher 18. Mother's Name Mary			•
, Man	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Gladys M. Downs (Sister-in-law) 19b. Mai 2928	ing Address (Street and Number or Rura B Alverta Ave. Balt	Route Number, C	ity or Town, State, Zip C	Code)
Baltimore,	. Page 1 al ment of H tant: If itel jury or oth		4 □ Donation 5 □ Other (Specify) Moreland	matory or other place)		Oc. Location - City or To Baltimore, 「	
Ball	permit Depart Impor any inj		Catha Soon	2. Name and Address of Facility Lassahn Funeral H	lome Bal	Ol Belair R Ltimore, Md	
	nysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac or		,	Approximate Interval Between Onset and Death
300	Examiner	ner	Sequentially list conditions, b. Due to or as a consequence of the conditions of the				
8	ate be executed ohysician and the burial-transit	l Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
09289	ificate be ng physicia as the bu	Medical	d				
Box 6	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Yea r
ds, P.O	requires that the de been signed by the should be detached	ed by P	Part II. Other significant conditions contributing to death but not resulting in the			cco use contribute to the	
Division of Vital Records,	rsician: The law red s certificate has be lirector, page 2 sho	Completed by	CORONARY ARTORY DISOR	5C	24a. Was an autopsy performe	d? prior to con death?	sy findings available apletion of cause of
Vital	nysician: ils certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check of the state of Doath (Check of the state of Doath of Doath of the state of Doath of Doath of the state of Doath o	only one)	e 6 Other (Specify)	1/0 000
ion of	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	27. Manner Death 1	les in	8d. Describe how		7.100
DIVIS	oital or At urs after c ral Direct illed in by		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, S	•	
	the Host thin 24 ho the Fune	Medical	29a. Certifier (Check (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 29b. Signature and title of certifier,	tigation, in my opinion, death occurred at ti death occurred at the time, date and place	he time, date and p , and due to the ca	lace, and due to the caususe(s) and manner as state	se(s) and manner stated. ted.
P				29c. License number 046360	290	Date signed (Month, Die 2008). Determine L	ay, Year) c, 2010
	311		30. Name and address of person who completed cause of death (Item 23a) (Type, Inc. 1) (Item 23a) (Type, Inc. 1) (Item 23a) (Type, Inc. 1) (Item 23a) (Type, Inc. 1) (Item 23a) (1 A Com Cum C	TENOT BI	ALTIMAR MI	02120F
	Stat Registra	-	DEC V8 2010 32 Hegistrar's Signature	arke			•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Jackson 11-25-2010 а м **5:**55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death \mathbf{PG} 4b. City, Town, or Location of Death Crescent Cities Center Riverdale Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 577-48-6617 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Year) 09–18–1934 Country) Washington DC Director 76 Yrs Usual Residence of Decedent shov 10a. State within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 346 Raleigh St. SE 20032 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Group Health Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Willie Golden Virginia Hines permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6394 Harvester Circle Douglasville, GA 30134 Darvell Jackson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-1-2010 4 Donation 5 Other (Specify) Harmony Memorial Pk Landover, MD In gnature of Funeral Service License 22. Name and Address of FacilitiRonald Taylor II SOMO 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysician/ disease or condition Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Exami that initiated events the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day ed by the a Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【XNo 24a. Was an page 2 s certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2**X** No Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one 29b. Signature

and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4409 East-West Highway

Tonya Hardy Riverdale, MD 20737 31. Date filed (Month, Day, Year)

arrend

D0058095

29d. Date signed (Month, Day, Year)

12/7/2010

Daniel Kuntz		State of Maryland / Department of Health and Mental H 1- For State Certificate of Death	ygiene	2010	08446
Physici Medical Exami		Decedent's Name (First, Middle,Last)	2. Date of Death Month December		3. Time of Death 1034 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3605 Hudson Street Baltimore		4c. County of Deat	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 215-82-93-11-1 Yrs. Wonths Days Hours Min. Usual Residence of Decedent	_	(MM/DD/YYYY) 9. Bi Forei Co	
Maryland 28a-f show any d at once.	tor	10a. State 10b. County 10c. City, Town or Location MD. Baltimore			10d. Inside City Limits 1 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1	vork done red) (First, Middle, Maral Route Numb	White, etc. Specify: U 16b. Kind of Business/ D/S/A aiden Surname) T, WR	rican Indian, Black, If TE Industry BLED GHT e, Zip Code) 12 24
Physician /Medical -xaminer		2.1a. Part I. Enter the disease, or or plications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Complications of Leukemia Due to (or as a consequence of):	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
e executed cian and rial - transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. AMENDED			
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical Certi	4 Homicide 4 Homicide 4 Homicide 4 Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	or Town, Stat	te) s) and manner as state	ed.
T with the connection of the c		and manner stated. 29b. Signature and title of certifier O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2		29d. Date signed (Mon December 1, 201	
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DHMH 17 Rev 1/20	_	OCME ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DeAnna Kitchen Month 20^{Year} Medical Dec 1900 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Archsine Lane Laurel 5. Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA 8. Date of Birth 1 ☐ M 2 🛣 🗆 180-30-6803 Months Days Hours Min 71 Director Jsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Prince George' MD Laurel 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7327 Archsine Lane 20709 USA Kitchen 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican Armed Forces? 1 Never Married 2 Married þ Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: American 3 K Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deanna 12th Grade NA Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Williams Dorothy Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7327 Archsine Lane Laurel, Maryland 20707 Karla Kitchen-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XIXBurial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cem. 12-11-10 Philadelphia, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 159 Wylie Funeral Rome P.A. 22. Name and Address of Facility 638 Ν. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☑ No Pregnant at time of death Day Year Yes detached 1 ☐ Yes ∠ v cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medica examiner? upleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 👺 No ျ 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Matural 5 Pending work Accident 1 Yes 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

UNTEL

30. Name and address of person w/o

31. Date filed (Month, Day Year)

4940

ENTIENT ATA

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kellman Month 12 Nathaniel 1909 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mayland Medical Center 01 Battimore N/A Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours (Month, Day, Year) 2/29/1925 Country) Director 214-20-2812 84 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD ANNE ARUNDEL **PASADENA** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 LIST AVENUE 21122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 - Widowed 4 - Divorced Specify. WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUSINESS OWNER APPLIANCES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ABRAHAM KELLMAN IDA ZELKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA KELLMAN/WIFE 217 LIST AVENUE, PASADENA, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 12/6/2010 REISTERSTOWN, MD 21. Signature of Fundal S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Onset and Death Schemic Medical resulting in death) Due to (or as a consequence of): Examiner LOhrs Sustained Tacoby caraia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Choleoystalis 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed Preumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No ျှ Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury s after death Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗔 29b. Signature and title of certifier 1275851255 schee 3 2010 December,

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State

Registrar

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31. Date filed (Month, Day, Year, DEC 0 8 2010

Fisher

Evere st

Baltimore

MD

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # 12 Per EH Collaboration Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ PM December 05 1105 2010 MAROLIN KUSHNICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Citu Singi Hospital of Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 05/10/1931 Hours 1 □ M 2 🗓 F 79 **Director** 214-30-5920 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director MD N/A XX Yes 2 No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number by Funeral 5908 SIMMONDS AVENUE 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify. Specify: WHITE Completed 3 ¥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) PHARMACIST PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ COHEN SYBIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5908 SIMMONDS AVENUE, RACHEL MASSRE/DAUGHTER BALTIMORE MD 21215 20b. Place of Disposition (Name of Date 20c. Location - City or Town, carner perentally Rather place)
AITZ CHAIM CEMETERY 12/06/2010 BALTIMORE, MD 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature of Funeral Service-Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 days disease or condition resulting in death) Tue to (or as a consequence of): Medical Examiner Sdays Chevic Drawchie Pulmining Disease Exacerbation Sequentially list conditions, Due to (or as a consequence of) frany, leading to immediate cause. Enter Underlying Cause (Disease or linjury certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, RES-000 Decimber 5 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ramela Damisse 5. noi Hospital of Baltimore 31. Date filed (Month, Day, Year) State 8 201 DEC 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2:30 AM LANGFORD JOAN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Min Director Usual Residence of Deceden or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe ral", or items 23a or Examiner must be Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip 💯 🗸 🛬 19a. Informant's Name/Relationship (Type, Print) 54 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 DEC CEM. 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 21. Signate once. In 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Consestie Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav 1 Yes 25 9 Unknown Yes 2 No been signed by the sahould be detached Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hask the Hospital or Attending Physician: The law autopsy page performed? 2 🗌 No this certificate 1 Tes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No ဂ္ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) DECEMBER4 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE, MD 2122 32. Registrar's Signature State Rowa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 5:25 AM Dec Medical 201 4a. Facility Name (if not Institution, give street and numb **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Marylan Bultimore 0 N/A 5. Social Security Number 6 Sex yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Months Nov 7. 1956 215-64-3914 54 Hours **Director** Yrs Maryland Usual Residence of Decede shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 546 Short Curve Road 21061 LISA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) US Government NSA 12 permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Allen Litzenberger Maude Elizabeth Clinedinst Theodore William Litzenberger (Brother) 8447 Spring Road Poordore Maria Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. Baltimore, Maryland 12.8.2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Myocardia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retai acc in the past 12 months? Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diaber Completed 1 √Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed prior to completion death? 2 💆 No Yes 2 No 1 Tes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} မူ 2 No Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

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32. Registrar's Sig

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Whitehursy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthia Whithurst 22 Streen 34

29d. Date signed (Month, Day, Year)

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2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CATHERINE LOUISE LATHE Month December 2, 2010 8:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2142 Harman Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 217-26-6926 Augon21 Day1930 Director 80 Yrs Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore N/A 1 🗌 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 2142 Harman Avenue USA 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 x No If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Jockel ျှ Robert Raeke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Raymond E. Lathe, Jr. (Son) 900 Saint Charles Avenue, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/7/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 237 East Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ pradicel disease or condition Medical resulting in death) Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year certificate has been signed by the resector, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Hyper lipidemia Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Matural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D0059914 2010 ress of person who completed cause of death (Item 23a) (Type, Print) DURST 1120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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		1 - State of M Registrar		epartment of Certificate of		Mental H	ygiene	38453
Physi	cian	1. Decedent's Name (First, Middle, Last)				2. Date of D	Death Day Yea	3. Time of Death
/Med		Margaret M.Liberto				DEC	05 201	- 10.7COU
Exam	iner	4a. Facility Name (If not institution, give street and number			or Location of Deat		4c. County of D	
Funera	al	FRANKLIN SQUARE Ito: 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birth	hday) If Under 1 Year	Sedal	8. Date of B	irth 9. E	Birthplace (State or Foreign
Directo		218-28-5036 1□M 2X F	79 _Y	rs. Months Days	Hours Min.	July 24		Country) ryland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			7,2,0,2 7,2,0	10d. Inside City Limits
Maryl I-f sho	į	Md. Balto.		Parkville				1 ☐ Yes 2☐ No
th the	Director	10e. Street and Number	1	10f. Zip Code			10g. Citizen of What	
ath will	rai	9213 Hines Estates Dri	ve		21234			USA
er deg	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ 1	t Ever in U.S.	13. Was Decedent of If Yes, specity Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	lo- 14. Race - Ai Black, Wi	merican Indian,
ours aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ∐Yes 2 ∭XNo			Specify:	White
72 hou	sted	15. Decedent's Education	16a. [Decedent's Usual Occu	pation		16b. Kind of Busines	ss/Industry
ithin he.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)	Give kind of work done life. DO NOT use retire	during most of wor ed)	rking		
Hygie ther th	S	12th 17. Father's Name (First, Middle, Last)	S	Secretary	40 M-45 1- N-		Offi	ce
id be the feet of ked of c eve	To Be	Joseph Anderson					e, Maiden Surname)	
And I yida I U Z I Z I D-UUJO 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. 1s marked other than "natural", or items 23a or 28a-f show raumatic event, the Mcdical Evol.	-	19a. Informant's Name/Relationship (Type. Print)	19b. I	Mailing Address (Stree		erine B	ber, City or Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the restrictions on the property.		Carmelo J. Liberto Spo	I	13 Hines E			rkville, M	
ges 1 If of H If iter		20a. Method of Disposition 1 □ Removal from State	20b. Place of I	Disposition (Name of crematory or other pla		Date	20c. Location - City	or Town, State
permit. Pages 1 Department of H Important: If ite any Injury or ot		4 ☐ Donation 5 ☐ Other (Specify)	Parkwo			0-2010	Parkville	, Md.
Department of the part of the		21. Signature of European Service Company		22. Name and Addr			unek Funer	
		23a. Part1. Enter the disease, or complications that cause	d the death. Do no	9705 B	elair Roa	d Nott	ingham, Md	21236 Approximate
Physician		Immediate Cause (Final	ine.		3 ,			Interval Between Onset and Death
/Medical			a consequence of					
Examiner		Sequentially list conditions, b b.	estive	hear	T failu	r-e		
uted 1 Insit	Examiner	Sequentially list conditions, if any harm time from the following cause. Enter Underlying Cause (Disease or injury	a consequence of	r				I
be executed sician and burial-transit		regulting is death) I and	a consequence of)):				
ficate be physici s the bu	Physician/Medical	d						
Sertific ding p	/Mec	IF FEMALE:						
leath atten	cjan	in the past 12 months:	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of d Month	lelivery Day Year
t the c by the achec	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	at time of dodd	3 La Other (specify)				
ss tha gned	by P	Part II. Other significant conditions contributing to death b	out not resulting in the	he underlying cause giv	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
requir een s nould						1 🗆	Yes 2□No 3□	Probably 4 Thknown
e law has b je 2 st	Completed					24a. Was	psy prior to	autopsy findings available completion of cause of
n: Th fficate or, pag		OF Was seen and want to be a first				perfo 1 □ Yes	ormed? death?	? es 2□No
yslcia s cert directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	ent 2 ☐ ER/Outp	atient 3 🗆 DOA Oth	26. Place of Dea			
ng Ph fter thi	T:n	27. Manner of Death 28a. Date of Inju	ıry 28b. Tin	ne of 28c. Inju			idence 6 Other (Sp how injury occurred	ecify)
tendli leath. or: A	catic	1 ☑Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	y, 10di/ IIIJC		Yes 2□No			
or At after d Direct in by	Certification:	determined 286. Place of Injury	ury - At home, farm c. <i>(Specify)</i>	n, street, factory, office		28f. Location (City or To	Street and Number or I wn, State)	Rural Route Number,
spital		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, o	death occurred at the ti	me, date and place	and due to the	cause(s) and manner	as stated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	i examination and/	or investigation, in my	opinion, death occu	rred at the time,	date and place, and du	ue to the cause(s)
To t To t	Σ	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
)		Yuling Zhang, M.D.			70605		Dec, 05	, 2010
		30. Name and address of person who completed cause of d DR Yuling Zhang 9000			\ - \ \ \ -	.2	LTO MO	1 2:33-
	ate	DR Yuling Zhang 9000 31. Date filed (Month, Day, Year) 32. Registra DEC 082010	ar's Signature	-in Jau	act C Ur	1 190	U MIO	- 61631
Regist	rar	DEC 0 8 2010 1	m ja.	parted				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State of M	arylan	-	artment of I tificate of I		and M		00	10	20151
			Registrar 1. Decedent's Name (First, Middle, La	st)	-	Cer	uncate of t	Jeain		2. Date of Dea	Reg. No.		38434
	Physicia Media		Edward N	elson			1	illv		Month 12		2010	3. Time of Death 10:15 a M
A.	Examir		4a. Facility Name (if not institution, give				4b. City, Town, o	r Location o	of Death		4c. County	of Death	
.4			Shining Moon Assisted 5. Social Security Number 6. S				Tows					timore	
H	Funeral Director			M 2 □ F 7. Age 90		ast birthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	Min.	8. Date of Birt	4 ^{Year} 1920	9. Birthp Count Mary I	lace (State or Foreign ry) a nd
	and show	ō	10a. State 10b. County		10c. City	y, Town or Loc	ation			-		11	Od. Inside City Limits
	Maryl 28a-f otifie	irec		ltimore		Towson							1 🗌 Yes 2 💢 No
	th the 3aor tben	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen of V	Vhat Coun	try?
	ems 2	nue	804 Seaword Road	12. Was Decedent E	ver in U.S	113 W	21286 /as Decedent of H	ispanic Orio	sin2 (Spec	rify Vos or No	USA		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Yes, specify Cuba	n, Mexican,	, Puerto F	Rican, etc.)		e - America k, White, e Whit	tc.
7	72 hou n"natu edica	plet	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give k	ent's Usual Occup ind of work done o	ation luring most	of workin	ng .	16b. Kind of Bu	siness Ind	ustry
72	/ithin /iene.	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DC	NOT use retired) Estate Br				Real E	state	Industry
Baltimore, Maryland 21215-0036	be filed v lental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Edward L. Lilly						r's Name		Maiden Surname		
lary	should and N is ma aumat	H is	19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailing	Address (Street a	and Number	r or Rural	Route Number,	City or Town, St	ate, Zip C	ode)
ა ა	and 2 Health sm 27 her tr		Miss Judy Lilly/ Daug	ghter			Southeran	Avenue	S.E.	Albuque	rque N.M.	8710	8
timor	: Page 1 at the trans of the tr		20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conte	Removal from State	CE		ition (Name of atory or other plac ervice Cor		12/8/	^{ate} /10	20c. Location - Towson Ma	-	*
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licens	th		²² e 53	Name and Address Opard J. R 05 Harford	is of Facility UCK Tr Road	nc Bålti	more Mar	yland 212	214	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	ne cause on each line.		. Do not enter	the mode of dying	g, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between
-1	Medical		Immediate Cause (Final disease or condition resulting in death)				Pream	aniA					Onset and Death
	Examiner			Due to (or as a	conseque	ence of):							
	7 ±	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ	ance of).							
8	cate be executed physician and the burial-transit	xar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ance of							
, ·	be exe sician burial	edical	resulting in deathy cast	Due to (or as a	conseque	erice or,.							
3/60	ficate g phy as the			a									
BOX 68	h certi tendin r use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	f pregnan	icy death 3 🗆	Ectopic pregnancy	,			23d. Date	e of deliver	у
). Bo	the deat by the at ached fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at g ☐ Unknown	time of de		Other (specify)				Mon	th E	Day Year
л. О	s that gned b	৯	Part II. Other significant conditions of		t not resu	Iting in the un	derlying cause give	en in Part I.				oute to the	cause of death?
SD	equire een si nould	eted	PALIVILE							1 🗆 Ye	es 2 12 No :	∃ Proba	ıbly 4 ☐ Unknown
Vital Records,	e has bage 2 st	Completed								24a. Was ar autops perforr	ned?/ pr	ior to comeath?	y findings available pletion of cause of
	ian: Th	Be C	25. Was case referred to medical				26. Pla	ce of Death	(Check c	1 🗆 Yes 🔞	2 No. 1	☐ Yes 2	□ No
=	hysic his ce al direc	ᅀᆝ	T LI TES ZILZ NO			R/Outpatient	Otho	. /			nce 6 Other	(Specify)	
5	ding P	;ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	28c. Injury work?	at	28		w injury occurred		
DIVISION OF	Atten	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury		ne, farm, stree		/es 2 □ N		Sf. Location (Str	eet and Number	or Rural 6	oute Number
2	ital or its afte al Dire	္က ု	4 El Homolde determined	building, etc.	(Specify)				-	City or Town		or ricital ri	oute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Check 2 Li Medical Examil	ician: To the best of mer: On the basis of exa e Practioner: To the basis	mination :	and/or investig	ation in my opinior	death occu	urrod at th	a time data and	d place and due t	a the seven	e(s) and manner stated.
	Not to to to to to to to to to to to to t		29b. Signature and title of certifier	1 101			29c. License	number		25	9d. Date signed (Month, Da	y, Year)
			remes a		SICIN	7	D507	-60			12/6/0	2010	
	10	1	30. Name and address of person who co	ompleted cause of dea	ith (Item 2 You	23a) (Type, Prir	D507	7,	LUT	heyle	MI	210	153
	State		31. Date filed (Month, Day, Year)	32. Registrar'	s Signat u	-	,		/				
	Registra		DEC 0 8 2010	Denera	13.	Marke	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 34 GM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Seco Social Security Number **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

ARY (AND If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 X M 2 □ F Months Hours Min. **Director** C Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Š 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES 10 VEN DOP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LESTER BERNARD CARTER 19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B JORDAN ANTONIO BALTIMORE MARVIAND 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - dity or Town, State Date 1 🗌 Burial 2 KCremation 3 🗌 Removal from State 108/2010 4 ☐ Donation 5 ☐ Other (Specify) REMATORI/ING BALTIMORE MARVIAND 22. Name and Address of Facility ThE DERRICK C. JONEST IH, P.A. Signature of Funeral Servic License AUE BALTIMORE, MARVIAND 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Due to r as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): the burial-transi attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month sate has been signed by the a page 2 should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Fas lune 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy . 24 hours after death.

• Funeral Director: After this certificate I leted filled in by the funeral director, pag performed' death? Yes 2 🛂 N Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 1 Uno M 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State	State of	Marylar	nd / Depa					lental Hy	gien	e		291.56
6.			Registrar 1. Decedent's Name (First, Middle, L	ant)		Cei	rtificat	e or L	Jeath			Reg. N	lo.	V	0400
	Physici		0.111	ast) Ine:	Morris	3					2. Date of De Month Decemb		ay 201	ear	3. Time of Death 4:45 pmM
4	/Medi Examir		4a. Facility Name (If not institution, g.				4b, City,	Town, or	Location of		Decemb	_	c. County of		4.45 Pitt.
7			1629 Taylor Ave		ĺ		, ,		hingt				Prince		orge's
	Funeral	1	Social Security Number 6.		7. Age (In yrs.	. last birthday)		r 1 Year	If Under		8. Date of Bir	th	T 0	9. Birthp	lace (State or Foreign
	Director		225-40-6571	1□M 2-20 F	97	Yrs.	Months	Days	Hours	Min.	(Month, De	28,	1913	Vir	ginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside City Limits
	Maryl f sho	ō		George's		rt Was		on							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	deorge 3	, 10	TL Was	10f. Zip					10a. C	itizen of Wh	at Coun	trv?
	h with	a D	1629 Taylor A	venue			1	0744				- J	USA		,
	deat	Funeral	11. Marital Status	12. Was Dece	dent Ever in L	J.S. 13.	Nas Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race -	Americ	an Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	/ Fu	1 ☐ Never Married 2 ☐ Married	1 Tes	2 🔼 No		r Yes, spe I∐ Yes		n, Mexican Specify:	i, Puerto i	Rican, etc.)			White,	^{etc.} 1ack
8	hours ural",	d by	3 Nidowed 4 Divorced	Year or Da	tes:								Specify:		
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7	withi iene. than the M	mc	Elementary/Secondary (0-12)	College (1-	4or 5+)		emake		,			Ot.7	n Home		
0	filed Hygin other ent, t	Be C	17. Father's Name (First, Middle, Las	t)		HOI	Chiake		18. Mother	r's Name	(First, Middle,				
Maryland 21215-0036	uld be flenta rked ric ev	To B	William H. Banks								Wood		,		
ary	shot and N s ma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address	(Street a			l Route Numb	er, City	or Town, St	ate, Zip	Code)
Σ	and 2 ealth n 27 i		Wilma. J. Cartw	right - Daw	ughter	1629	Taylo	or Av	enue,	, For	rt Wash	ing	ton, M	1D 2	0744
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from S	20b. I	Place of Dispo	sition (Nan	ne of ther place	e)	D	ate	20c. l	Location - Ci	ty or To	wn, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Spec		Ch.	cemetery, crem Olive urch Ce	Bap	tist ry	D	ec.9	,2010	Li	incoln	, Vi	rginia
Baltimore,	ermit Depar mpor ny in		21. Signature of Funeral Service Lice	ensee					s of Facility		oudoun			*	
	TO = 60	\dashv	meni	nand	Se .								esburg	, Vi	rginia
	1000		23a. Part1 Enter the disease, or consheck, or heart failure. List only	nplications that ca / one cause on ea	used the deat ch line.	th. Do not ente	er the mod	e of dying	g, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
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8/60,	death certificate be executed e attending physician and d for use as the burial-transit	dical	•	_d	JIL FOI.	led dia	betes	s mei	.11tus	5				_ 2	months
S X	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after detail. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	w 1	IF FEMALE:	23c. If yes, outc	omo of proces	0004									
X Q Q	atten for u	sician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2 □ Feta Intattime of d	al death 3 🗆	Ectopic pro						23d. Date of Month		ry Day Year
j.	the d	Physi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknov		realii 5	Other (spi	eury/							
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records,	equire en sig ruld b										1 🗆 1	es 2	2 □ No 3[☐ Proba	ably 4⊠Unknown
	law re	Completed									24a. Was		24b. We	re autor	osy findings available
	The ate has page	E										sy rmed? 2⊠N	dea	ıth?	npletion of cause of 2□ No
N I S	clan: ertific	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		<u> </u>	100	2010
5	Physician: r this certific ral director,	၉	1 Yes 2 No			ER/Outpatient			4 LI Nur	sing Hom	ne 512 Resid	dence	6 □Other	(Specify)
	ling F	ö	27. Manner of Death 1 Natural 5 Pending		Injury , <i>Day Year)</i>	28b. Time of Injury		8c. Injury Work?			8d. Describe h	ow inju	ury occurred		
VISION	death death ctor: y the	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		finium - At ho	ome farm etre	M et factor		es 2 □ N		06 Lagation (6	24	101	-	
2	after after Dire	Certification:	4 ☐ Homicide determined	building	g, etc. (Specif	ome, farm, stre	ot, lactory	, onice		20	City or Tou	n, Stai	te)	or Hurai	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Pi	nysician: To the b	est of my kno	wledge, death	occurred a	at the time	e, date and	d place, a	nd due to the	cause(s) and mann	er as st	ated.
	n 24 l he Fu hetel	Medical	(Check only 2 ☐ Medical Exal	miner: On the bas and manne	⊪s or examina	ition and/or inv	estigation,	in my op	inion, deatl	h occurre	ed at the time,	date ar	nd place, and	d due to	the cause(s)
	To t	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (A	Month, L	Day, Year)
			It gatech i					2025	6			12/	01/201	0	
			30. Name and address of person who					יי נוו	lach t	. ~ + -	DC				
		0	Elizabeth Who	alon, MI	oistrar's Skopa	19th	DL. N	w, W	asnır	igtor	ı, DC				
	Stat Registra	-	DEC 0 8 2010	Beren	A.	harke									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Alexander Marshall, Sr. December 2010 2:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Homestead Manor Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Months 217-03-9887 Director Maryland 91 Nov. 10, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 17 is marked othar than "natural", or Itams 23a or 28a-f show traumatic event. The Mudical Examinar must be invitibed at 10d. Inside City Limits 1 Yes 2 No Maryland Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7950 Belhaven Road 21122 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: ₩ Ⅱ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Lieutenant Firefighter Baltimore City 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill thent of Health and Mental H tent: If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Surname) Samuel. Marshall Shellhaus Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Marshall, Jr (Son) 7950 Belhaven Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
any injury or otl Cedar Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 12/07/2010 Brooklyn Park, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the signed by the attending d be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 page certificate 2 No 1 ☐ Yes 2□ No 1□ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify 20 No Hospital: ٩ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Nothin 24 hours after death.

To the Funeral Director: Aft Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005325 2010 30. Name and address of person who completed cause of death (Item 29a) Tyge, Print) Preston MelindaButter 21655 136 led num am Avenue parke 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0820 Registrar

DHMH 17 Rev 1/200

1-Certificate of Death 3. Time of Death 2. Date of Death Dav 11:45 AM Physician t. 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number Examiner Baltimore Home Nursina tesw:ck 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 88 Months Days Hours 1**⋈**M 2□ F Director 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Baltimore 1 Ses 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Івете 23а ог 2120 USA oreenspring 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 🗷 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during life (DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) during most of working permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "na any injury or other traumatic even". Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) vovella 6:650n Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro 6310 Greenspring 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 12-10-10 21. Signatu e of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Demena **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 这 Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 1 ☐ Yes 2 ☑ No 4 🗀 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has 1 Yes 212 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 [Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3510 December (Inmo) 2010 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Baltimore 5901 - reet DON M-D n- cHayles

Registrar

State

31. Date file property Pag Year)

parke

32. Registrar's Signature

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DHMH 17 Rev 1/2001

10-09335 Dell Mackay Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

II Ma	ckay		1- For State	ate of Maryla		artment of rtificate of		and	Menta	al Hyg		Reg. No.	20		3845	(
	Physici	an/	Registrar 1. Decedent's Name (First, Middle	,Last)						2.	Date of De	eath			3. Time of Death	_
	l Exami					M	ackay	Y		ī	Month Decemb				0011 hrs	
			4a. Facility Name (if not institution		imber)	4	b. City, Tov		ocation of	Death			. County of		atu	
			16 Old Court Road Rm		7 A == (= :====	Pikesville yrs. last birthday) If Under 1 Year If Under 24Hrs.			24400	Baltimore Count 8. Date of Birth (MM/DD/YYYY) 9. Birthp			<u>, </u>	_		
	Funeral Director		=-	6. Sex	7. Age (In yrs.		-	Days		Min.				Foreign	1	
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	how s	_	MD Ba	ltimore		Pi:	kesv:	ille	е						1 Yes 2 No	o
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7	with ns 23 be no	ā	11. Marital Status		edent Ever in U		Decedent es, specify (10-	14. Race - White,		an Indian, Black,	_
	death or iten	Funeral	1 Never Married 2 Mar	1 Yes	2 X No					rueito Ric	an, etc.)	i				
•	ral",	þ		rced If Yes, Give Yea or Dates:		16a, Decedent	Yes 2						Specify: (ind of Bus			_
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36	e. than dical	ple		• •	40,00,	Dr	essei	_				Br	i to	Гэл	ındry	
215-0036	ygien ygien other he Mo	Completed	7th grade 17. Father's Name (First, Middle, I	_ast)		F L	<u> </u>	18	.Mother's	Name (Fi	irst, Middle	, Maiden	Surname)	цас	mar y	_
215	be file ntal H rked c	Be (General Rile 19a. Informant's Name/Relationsh	У							Rile					
27	nd Me is ma	ဥ				19b. Mailing										
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Baltimore,	ermit Depart mpor njury		21. Signature of Funeral Service L	icensee K		22. No M	ame and Ada	F/F	f Facility H We	st						
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	ysician Iedical		failure. List only one cause of	n each line. a. H yperte nsiv							,				Between Onset and Death	1
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o ·	be ex sician surial	edical	UNPENDED	AMENDED												
Box 68760	Incare	n/M	IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg irth		al death	3	Ectopic p	oregnancy	,		I. Date of d Month	elivery Da	ay Year	
9 ×	th cert	icia	past 12 months?		ant at time of de		er (Specify)								
8	the att	Physician/Me	1 Yes 2 No 9 Unkr	9011816							00- Did	1-1			ne cause of death?	_
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Records,	icate page	Completed									1 Yes	2 N	1 6	✓ Yes	2 No	_
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Division of Vital	er dea	icat	•	gation 28e. Place	e of Injury - At h	ome, farm, street	t, factory, of	ffice buil	lding, etc.	281			nd Number	or Rura	al Route Number, City	,
Š	rs aft	Certification:	3 Suicide 6 Could 4 Homicide								or Town,	State)				
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Division of Vital Records, P.O. Box 68760,	To the Hospital of Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical		iner: On the basis of and manner s		and/or investigation				urred at the	e time, dat					_
	, , ,	Σ	29b. Signature and title of certifier	17				icense r							h, Day, Year)	
			Maryente It	ne I'me	l			D.C.M.	.c.			Dec	ember 5	, 2010		
	5		 Name and address of person was Margarita Korell MD. 	who completed cause Assistant Med			nn Stree	et. Balt	timore.	MD 213	201					
		tate	31. Date filed (Month, Day, Year)		gistrar's Signat	ure		., _ = 10								_
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DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g910, 12/08/2010 dhb Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Albert ^D2^y3, Francis McCarthy 2010 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 6. Sex 1. M 2 □ F Funeral Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. April 4 77 Director 579-40-2423 Yrs Washington D.C. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13727 Lionel Lane 20853 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Race - American Indian. 1 Never Married 2 Married Black, White, etc. 2 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Tour Guide Tourism Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ James Thomas McCarthy Pauline Elizabeth Pidgeon 19a. Informant's Name/Relationship (Type, Print)

19a. Sister-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13727 Lionel Lane, Rockville, MD Law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 11/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service License MO0382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Onset and Death Fhoole Fuysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Septic Shock secondary to Pneumonia Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Practioner: To the best of my knowledge, shall occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 124/10 168658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Longin MB 18101 Olney Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kelvin Donte McClelland State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First_Middle Last) 2. Date of Death 3. Time of Death Month Day December 5, 2010 Medical Examiner 0939 hrs Kelvin Donte' McClelland 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4603 Park Heights Avenue Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Foreign Hours Min Director 1 X M 2 F 36 Country) 09 74 11 MD 220-86-086] Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "natural", nr items 23a or 28a-f show
injury ar rather traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 Park Heights Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XNever Married 2 Married 2X No Black 3 Widowed If Yes, Give Year 1 Yes 24 No specify: 4 Divorced Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Bank Teller Marketing 3yrs MBNA 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ Harry A. McClelland

19a. Informan's Name/Relationship (Type, Print) Louise Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 Park Heights Ave, 20b. Place of Disposition (Name of cemetery, Date Louise McCelland-Mother Baltimore, Md 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Arbutus Memorial 12/11/2010 Arbutus, Md Donation 5 Other Specify 21. Signature of Funeral Service Licer 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 28a Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Modical Death Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical 23a,pt.II,27 per me g914 4-13-11 vt burial -X UNPENDED g physician a AMENDED .O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š σ. 1 Yes 2 No 3 Probably 4 Unknown clinical history of hypertensive cardiovascular Records, Completed this certificate has been I director, page 2 should 24a. Was an 24b. Were autopsy findings available disease and diabetes mellitus, schizophrenia autopsy prior to completion of cause of performed? death? Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital B Hospital: 1 Inpatient 2 ER/Outpatient 3 COA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes After 1 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the more within 24 hours after death

To the Funeral Director: Af Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 1 one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1347 PM Gilbert Michael Decemba 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Buyuraw Medical Contor Bultimon . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Ye. January 6, 1 **X** M 2 □ F 217-26-5028 78 Maryland **Director** 1932 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director Baltimore Dundalk 1 Yes 2 Xo MAryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 21222 2235 Searles Road USA items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: White Specify 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic mach. Elementary/Seconday (0-12) College (1-4 or 5+) Steel 10 years Medalorgist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gilbert J. Michael Jane Brightwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2235 Searles Road, Dundalk, Maryland wife Rose Marie Michael 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 8, 2010 Dundalk, Maryland Sacred Heart of Jesus Cem.! 4 Donation 5 Other (Specify) Signature of Funeral Service Lice Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Pale 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or illijury that initiated events Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, page 2 🗌 No 1 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 1 Yes ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending work 1 Tes 2 No after death ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D-0061115 December 4,2010

Registrar

DHMH 17 Rev 7/2009

State

Q

Hardin

31. Date filed (Month, Day, Year)

Pantle

Avenue

Baltimore, Maryland

21224

4940 Eastern

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day, December Charles Gilbert Margolis 2010 3:26 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days March 1 ▼ M 2 □ F Hours Washington D.C 212-38-2821 69 Yrs. Director 1941 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3352 Chiswick Ct. Apt. 1-E 20906 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify White Specify 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Shoe Salesman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on my injury or other traumatic eve ပ Margolis Pauline Pear1 Michelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Margolis / Son 8337 Mary Lee Lane, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory ! 12/7/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
app Funeral and Cremation Services
33 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Ligens MO0382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arkinsor disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ementic Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami pertensión Hospital or Attending Physician: The law requires that the death certificate be executed ician and bunial-trans resulting in death) Last Due to (or es a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 1536 10 D67275 MD nama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

50 IRvine St NW Washington DC 20422

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Mozell McNair 10:50 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ndallstown Balhmou Vorthwest If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219.18.4277 1 🗆 M 2 🔀 94 (Month, Day Year) North Carolina Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21207 United States 3809 Arbutus Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within Own Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Queen Ester Hartsfield Dave Crudup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Beverly Mc Nair-Dixon /Daughter 3809 Arbutus Avenue Gwynn Oak, MD 21207 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec 13 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Beltsville, Maryland 2010 Chesapeake Crematory 22. Natirematives family Funeral Alternatives Molley 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Eriter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ uthuroscuertic layt disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner pertension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due of or as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 death? 2 No 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MD HOO65959 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 540 Crust Rd DO Ola , Vatkins 31. Date filed (Month, nature State **DEC 08** Registrar

DHMH 17 Rev 7/2009

CS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical Year Mary cember 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year)

And Days Hours Min. (Month, Day, Year) The Johns Hopkins Hospital 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 226-60-4608 Director IRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits wishing a remarked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at e.e. BAITIMORE 1 Yes 2 □ No Director MARYland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA Altimore 2/2/3 Funeral 95 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 → No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced HMERICAN Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DANRIVER Mills 17. Father's Name (First, Middle, Last Be DAVIO ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau
once. Cumber And Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Dațe 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) 22. Name and Address of Facility
WARCH M. WALLACE FUNERAL
3405 C. FRANKIN SHEET BALLIMORE. 21. Sign ture of Funeral Service Licenses allace MARULAND 21229 23a. lart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirth, or not art failure. List only one cause on each line.

Immediate Calle Approximate Interval Between Onset and Death **Physician** Acute Ischemic Strake disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 № No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes Z√ No 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Natural. Injury

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician; 24 hours a

5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Myata, no RES-000

December 5, 2010

600 North Wolfe St, Baltimore, MD, 21287

Registrar

DHMH 17 Rev 1/2001

State

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wing ate,

MD

32. Registrar's Signature

Jamie

31. Date filed (Month, Day, Year)

DEC 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 6 Day 2010 Year Physician/ 6:00 AM Jennifer Ruth McBride Medical 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Joppa 2906 Woods End Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 - M X-X June 13. 1935 Mary Tand 213-32-1171 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State Funeral Director Harford Joppa Maryland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 USA 2906 Woods End Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 MMarried White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: If Yes, Give Year or Dates 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Glen L. Martin Airport Mathematician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ruth Debelius Jennings Moser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2906 Woods End Drive Joppa Maryland 21085 Robert McBride/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ⊠ Burial 2 □ Cremation 3 □ Removal from State Highview Mem. Gardens 12/10/10 Fallston Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Rock 5305 Harford Road 21. Sonat no f Funeral Service Licenses Inc Baitimore Maryland 21214 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. PH LURE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical KVER 54EBR Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death hed by the a 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed^a 1 ☐ Yes 2 ☐ No 2 🗆 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural iniurv 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 4 45/16389

Registrar DHMH 17 Rev 7/2009 arke

Mrs.

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VALARBO

DECEMBER 7, 2010

1716 HARFORD RASHIOS FALLSTON HD 2104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 3. Day 2010 2:48 P. Dorothy Snowman McNally Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) 101 yrs. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Hours 0ct/00er Pay 8 ear) 1909 Mar VI and Director 212-03-6254 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore Parkville Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 8304 Nunley Drive Apt. B 21234 USA 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Rlack. White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working e. DO NOT use retired)
Staff Assistant Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company age 1 and 2 should be filed with ont of Health and Mental Hygien of titem 27 is marked other ity or other traumatic event, they or other traumatic event, they are the other traumatic event, they are the other traumatic event, they are other traumatic event, they are the other traumatic event, they are the other traumatic event, they are the other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Frank Snowman Elizabeth Vogel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 W. Elm Avenue Baltimore Maryland 21206 Sheila A. McCoy/ Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State Department or Important; If any injury or 12/8/10 Timonium Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Båltimore Marvland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): by the attending physician and stached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? monteen Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) Carri 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1)

Registrar

31. Date filed (Month, Day, Year)

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			Please amend #10 1 - State Amend Item	Type or Print led 19b Per Fi State of Mary as 23aPtII,2	in Black H G910 Jand / De 8b per C	Indelible l 12/15/10 partment o me,g910, ertificate o	nk, Ensure f Health and 12/08/2010 f Death	All Copie: Mental Hyd and	s Are Leggiene	gible.	38468
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H	Funeral Director		5. Social Security Number 219-26-2213 Usual Residence of Decedent	ex 7. Age (In 7. Age (In 71)	yrs. last birthda Yrs.	Months Da			1939	9. Birth Cou	nplace (State or Foreign ntry) PA
	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County MD Baltimo		c. City, Town or Timoniu						10d. Inside City Limits 1 ☐ Yes 2 💢 No
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9036	urs after d ural", or i il Examin		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 ☐ Yes 2 💢		to ricall, etc.)	Specif	ack, White,	White
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State mend Items 23aPtII,25 per me,g910,12/08/2010dhb
Registrar

Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2 Physician/ Eyvonne Moss Medical Eacility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MEDICAL HARLE LATA ENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8 Date of Birth Funeral Jan. 4, 1944 Days Min. 1 □ M 2 🛛 F 66 Yrs. Director 415-68-4425 Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 X Yes 2 No She1by Memphis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A 38106 1996 Martin Circle should be filed within 72 hours after death v n and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give **Black** 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Regional Medical Ctr 12th Therapist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Jessie Neal Brown Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3445 Hyacinth Pl., Waldorf, MD Department of Health Important: If item 27 any injury or other tr Stacy Evans Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 12/4/2010 Memphis TN 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 38109 TN12 S. Parkway West, Memphis, N.J. Ford FH, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between hock, or heart failure. List only one cause on each line Brokasi Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine a sontaguenge of) cause. Enter Underlying 100 Cause (Disease or iinjury 00 PPROVER BY MEDICAL EXAMINER that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): CERTIFICATIO Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to pleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SLO 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed tentro a Str 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy nou death? performed due to complications of diabetes mellitus 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1X Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 28 93 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 GARRETT AVE LAPlata Md JOG46 CIL 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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mine	•	4a. Facility Name (if not institut			4b. City, Town, or Locat	ion of Death		4c. County o	
		BALTIMORE WASHI 5. Social Security Number	NGTON MEDICAL CE	ge (In yrs. last birthday)	GLEN BURNIE If Under 1 Year If Ur	nder 24 Hrs. 8.	Date of Birth	ANNE ARU	9. Birthplace (State or Foreign
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#20b.c.perFH.G910,12/8/2010,ws#31perDVR
State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ Samuel Nickens, Sr. P.M .19 2010 Medical تتمل City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 730 Linnard Street Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 9 Maryland 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1√□ M 2 □ F 81 214-26-2332 1929 Director Sept Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore N/A 1X Yes 2 ☐ No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 Funeral 730 Linnard Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc Black ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify: If Yes Give Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic Arrid Van Lines College (1-4 or 5+) Elementary/Seconday (0-12) Construction Worker 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Foreman မ Eugene Nickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
730 Linnard Street Baltimore, Mary Land 21229 19a. Informant's Name/Relationship (Type, Print) Celestine Nickens/ Wife Glen Burnie, MD 20b. Place of Disposition (Name of 12/9/10 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenenaventomenter Park Garrison Forest Vet 12 cento 22. Name and Address of Facility Chatman - Harris Funeral Home Signature of Funeral Service Licens 5240 Reisterstown Rd Baltimore, MD 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest encock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Pinal VATURAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on physician and s the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No atten for Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Records, Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performed? death? 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 \sum Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and t le of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature
DEC 0 8 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William 26, 12:30 P M John 0'Hara 2010 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8100 Connecticut Ave. #1419 Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Yrs. Director 89 Nov.2,1921 169-14-6265 Pennsylvania Usual Residence of Decedent r 28a-f show a notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Director MDMontgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with rai", or items 23a or Examiner must be r 8100 Connecticut Avenue, #1419 20815 Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White 2 Specify: 3 Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 4+ Engineer Computer Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John William O'Hara Bridget Cahalan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6817 Old Stage Road, Rockville, MD 20852 be of Disposition (Name of Date 20c. Location - City or Town, State Susan O'Hara -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec.1,2010 Alexandria, Virginia 22. Name and Address of Facility Neptune Society 8570 Del Webb Blvd., Las Vegas, NV 89134 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the de or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mp diat Cause (Final sease or condition resulting in death) **Physician** Metastatic Lung Disease 1 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 I Inknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Coronary Artery Disease 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Malignant Melanoma 24a. Was an autopsy performed? 1 Yes 2 2 No Dementia Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation Injury of the state of the state.

• Funeral Director: Af letely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔯 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0061630 November 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shishir K. Khetan, 1201 Seven Locks Road Rockville, MD 20854 31. Date filed (Month, Day, Year, 32. Registrar's Signature State DEC 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Hospice Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | (0/12/1942 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-38-9655 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if fiem 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event. the Medical Forming 1. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No MD BALTIMOR 10g. Citizen of What Country? 10e. Street and Number Funeral ROSEWOOD 21215 U.S.A 2603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) EQUIPMENT Elementary/Seconday (0-12) College (1-4 or 5+) ARE HOUSE MAN Be 18. Mother's Name (First, Middle, Maiden Surname) UNK NCWN 17. Father's Name (First, Middle, Last) မ PARKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 19a. Informant's Name/Relationship (Type, Print) PARKERJR CHARLES AVONDALE ROAD. BALTIMURE, MARVIAND 20c. Location - City or Towh, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11 2010 BALTIMORE, MARYIAND CARMEL CEME. 4 Donation 5 Other (Specify) 22. Name and Address of Facility The DERRICK C. JONES FIH, P. 4. 21. Signature of Funeral Service Licenses 4611 PARK HETS. AUE. BALTIMORE MARVIAND 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BL ADDER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy tate has been signed by the atte page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn After this certificate ☐ Yes 2☐ No Yes director. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မှ 1 Tes the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred Certificate: 5 Pending Investigation injury 1 Natural 2 🗌 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

24 hours after deat Funeral Director: сопрете within 2.

> State Registrar

(Check

only one

29b. Signature and title of certifier

MANO

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a, 25 per dr., 2910, 1270872010dhb
Certificate of Death
Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month NATHAN PARSONS PM DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Funeral Hours 1 XM 2 🗆 0270671920 Director 212-07-9089 90 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 🗌 Yes 2 🔽 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 7920 SCOTTS LEVEL ROAD 21208 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 ₩ Widowed 4 Divorced Specify. WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 OWNER AUTOMOBILE INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN marked ည UNKNOWN UNKNOWN PARSONS permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY PARSONS/SON HOMESTEAD DRIVE, #2A, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other pla BETH JACOB ANSHE VESHEAR CEMETERY 12/3/2010 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. illou 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, conshock, or heart failure. List only complicity ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one of use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ IRINARY TRACT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 10CARDIAL INFARCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1 🔁 Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo D54352 DECEMBER 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINCEL TOOK NOITHWEST MOSPITAL COURT 5401 OLD ROND RANDALISTOWN MD 21133 31. Date filed (Month, Day Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryland		rtment of H tificate of D		Mental Hy	_	2010	38476
	D		Registrar 1. Decedent's Name (First, Middle, Las	t)		Cert	incate or b	Calli	2. Date of De	Reg. N eath	6. U : U	3. Time of Death
	Physicia Medio			Annie	G	. Phi	illips		Month 12	_6 [□]	2010	8:45 ам
	Examin	er	4a. Facility Name (if not institution, give 1627 E. 25th S				4b. City, Town, or Balto	Location of Dea	th	40	c. County of Dea	ath
	Funeral		Social Security Number 6. S	x 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hr		th	9. B	irthplace (State or Foreign
	Director		214-12-2918 ¹ Usual Residence of Decedent	□ M 2 X F	90	Yrs.	Months Days	Hours Mir	. (Month, De	192	0 0	ountry) VA
	and show dat	Į	10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	28a-f	irec	MD na		Balt	timor						1, Yes 2 □ No
1	ith the 23a or st be r	ral	10e. Street and Number	. .			10f. Zip Code			_	itizen of What C	Country?
=	tems termu	Funeral Director	1627 E. 25th S	12. Was Decedent Ev	er in U.S.	13. W	as Decedent of His	spanic Origin? (5	Specify Yes or No-		S A 14. Race - Am	erican Indian,
မ္တ	апего Г", or i катin	ğ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	lo		Yes, specify Cubar ☐ Yes 2 🕱 No		to Rican, etc.)		Black, Whi	ite, etc. Black
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om.	permit. Fage I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant if firem 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Sther (Specify	Removal from State	ceme	etery, crema eenmo	atory or other place		23-2010		-	
Baltimore, Maryland	permit. Departn Imports any inju		21. Signature of Fun Service Leas				Name and Address	s of Facility $M \delta$	arch Ea	st	F/H	
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P	nysician/	vo 0	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Lina	P 1.		Ecul	n -A	1031,		Approximate Interval Between Onset and Death
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To the	within To the comple		only one) 3 X Certifying Nurse 29b. Signature and title of certifier	Practioner: To the be	st of my kno	owledge, de	29c License		ace, and due to the		s) and manner as te signed (Mont	
			FILL	MH	ans)	1/4/34	7326		Dea	ember	6,2010
	2		30 Name and address of person who co	ompleted cause of dea	th (Item 23a	a) (Type, Pri	Chap	Strep	4 77) 7	Y-2	mi	212061
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	Registra	ir	DEC 0 8 2010	(None and	12. 16	Jacks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ therine etrides 07:30 AM 02 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Dulaney Valley Retirement Center Baldwin Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Days Months Hours Min. (Month. Day. 108315 0 PA Director 10 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director notified MD Baltimore Baldwin 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ritems 23a or ner must be n ö 10g. Citizen of What Country? Completed by Funeral USA 5001 Carroll Manor Rd. 21013 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian "natural", or iten edical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxx No Yes, Give Specify. 3 Midowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever ၉ Diane (unknown) George Augerinos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21234 Mr. George Petrides/ Son 1815 Deueron Rd. permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tonce. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Greek Orthodox Cemetery 12/06/2010 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Rd Leonard J. Ruck, Inc. Baltimore. MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? atter for u Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the f Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medica only one) Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 131119 son who completed cause of death (Item 23a) (Type, Print) Digital Dr #G. seem - 010 31. Date filed Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend State Registrar	Item St	ate of M	larylan I r , g	d/Depa 910,12 Cer	itment of 7087201 tificate of	Health Death	and N	∕lental Hy	giene Reg. No	• • 2 A	10	201.70
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	Medic Examin		4a. Facility Name (if not institution					4b. City, Town	, or Locatio	n of Death	I NOV			of Death	
			Howard Co	unty 16. Sex	Gene			Colu If Under 1 Ye	mbia		P		Ho	Naro	
	Funeral Director		219-48-8520	1 X M 2		ge (in yrs. ia 64	as <i>t bir hday)</i> Yrs.	Months Day		er 24 Hrs. Min.	8. Date of Bir May 28	th 'y, <i>Year</i>)	46	9. Birthpl Counti	ace (State or Foreign Y) unk
			Usual Residence of Decedent			T									
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	death r item iner m	, Fur	11. Marital Status unk	Ar	r <u>m</u> ed Forces?		unk 13. V	Vas Decedent o Yes, specify Cu	f Hispanic C ıban, Mexic	origin? (Spean, Puerto	ecify Yes or No- Rican, etc.)			e - America k, White, e	
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Jan.	shoul		19a. Informant's Name/Relations		•						al Route Numbe			tate, Zip Co	ode)
e,	and 2 Health tem 2		Howard County 20a. Method of Disposition	Genera	II HOSP	_		sition (Name of	Lane,		ımbia, M			City or Tov	un Stata
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. In marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 X Other (, C6		atory or other p	lace)		Date	200. L	ocation -	City or 10v	vii, State
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	Physician/ Medical	ř	disease or condition resulting in death)	a	Due to (or as	tic	Sho c	K							Week
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_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transicompleted filled in by the funeral director, page 2 should be detached for use as the burial-transicompleted filled in by the funeral director, page 2 should be detached for use as the burial-transicompleted filled in by the funeral director, page 2 should be detached for use as the burial-transicompleted filled in by the funeral director, page 2 should be detached for use as the funeral director.	Medical	29a. Certifier 1 Certifying (Check 2 Medical I	Examiner: On	n the basis of e	examination	and/or investi	aation, in my on	nion death	occurred at	the time date a	nd place	and due	to the caus	e(s) and manner stated
	Fo the within to the comple	Σ	only one) 3 Certifying 29b. Signature and title of certifie	Nurse Prac	tioner: To the	best of my	knowledge, d	eath occurred at	the time, da nse number	te and plac	e, and due to the	e cause(s	s) and ma	nner as stat (Month, Da	ed.
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			30. Name and address of person		ted cause of d	leath (Item									-
	Stat	Α	SANDER B. 31. Date filed (Month, Day, Year) DEC 08	1NS4L	2. Registra	ar's Signak	ure .	rter V	rive	4	umbiq	+ 1	ID	2104	4
	Stat Registra	ır	DEC 08	2010	Dencia	1 1.	par	es!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth 04-2010 0720 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min 02-06-1938 219-26-9061 Director 72 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Harford Bel Air 1 Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 621 Camelot Drive 21015 IISA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No 9 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates is marked other than "natural", Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event, the Me. College (1-4 or 5+) Occupations Consultant Fast Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Rosario Rollo Mary Bandiera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Rollo (Wife) 621 Camelot Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) BelAir Mem. Gardens 12-07-2010 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PTASTATI disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nonsiduenne of) Physician/Medical Examir The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certificate I completed filled in by the funeral director, page PULMONARY EMBOLISH performed' 2 🗆 No Yes 2 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🐧 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

new

Year)

31. Date filed (Month, Day,

nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Maryla	_				and M	lental Hy	/gien	е			
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major	Examir	er	4a. Facility Name (if 4419 Furle	y Avenue		mber)		Baltim	nore	Location o	of Death			c. County /A	of Death		
	Funeral Director		5. Social Security Nu 214-30-3717	,	6. Sex 1 🔀 M 2 ☐ F	7. Age (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 10/22/	rth 1931		9. Birth _l Coun	place (State o	r Foreign
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	10 B	17. Father's Name (F	·irst, Middle, La	D.		R	iley		18. Mothe		(First, Middle		Surnam A.	e)	Cullen	
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Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n- determin	28e. Place	e of Injury - At h ling, etc. (Spec <i>it</i>	ome, farm, stre iy)	eet, factory,	office		2	8f. Location (City or Tov			er or Rural	Route Numbe	er,
Ω	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2		Physician: To the laminer: On the ba	sis of examination	on and/or invest	idation, in m	v opinion	 death acc 	curred at t	he time, date a	and place	e, and due	e to the cau	ise(s) and mar	nner stated.
	To the To the To the Comple		only one) 3 29b. Signature and t	- 17	Nurge Practioner:	To the best of m	ny knowledge, c		ed at the License i		and place	, and due to th			anner as sta d (Month, L		
			▶ Clas	relex	payott	W/			712	546			Dec	6	20	00	
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	Stat Registra	_	31. Date filed (Month	o, Day, Year) 0 8 2010	. 67	Registrar's Signa	barke	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. Sallie Woodson Scott 2010 0010 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep. 19, 1 **Funeral** 9. Birthplace (State or Foreign Months Hours Min Virginia Director 220-26-0842 85 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "---10b. County Director 10c. City. Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 15310 Beaver Brook Ct., Apt. 3C USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) School Counselor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julien Ashleigh Scott Emma Woodson Lankford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Ringe Drive, Severn, MD David Scott - Nephew 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State remetery, crematory or other place)
Franktown
Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12-08-2010 Franktown, VA Signature of Funeral Service Lacensee 22. Name and Address of Facility B. D. Holland Funeral Home 7342 Lankford Hwy., Nassawodox, VA 23413 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ Failure to thrive Medical resulting in death) Due to (or as a consequence of Examiner Lower extremity cellulitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the day of the cause of the caus Examine Due to for as a consequence of and I-transit requires that the death certificate be executed Liver cirrhosis that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Sepsis attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 ANo After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ၉ 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 \square Pending work 1 Tes 2 No Accident Investigation after deat Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician; The law 24 hours a сотрыете within 2 To the I

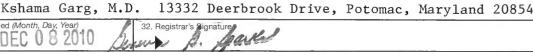
> State Registrar

31. Date filed (Month, Day, Year 08

3 🗆

29b. Signature and title of certifier

only one)



30. Name and address of person who completed cause of death tem 23a) (Type, Print)

2010

29c. License number

D60826

29d. Date signed (Month, Day, Year)

December 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 37 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 10Rbi olfmore **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Months Min. 1 X M 2 - F Hours (Month, Day, Year t 15, 1932 Mary Land Director 215-28-8330 78 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d, Inside City Limits Examiner must be notified Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1421 Clarkson Street USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Business Forms Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Raymond E. Swope Mary E. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. Swope wife 1421 Clarkson Street Baltimore, Maryland 21230 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dec 3, 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Priysician/ YICANDIN disease or condition Medical resulting in death) Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of): attending physician if or use as the burial. Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the detached g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CONGETIVE REANT PAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUCTIVE 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Μ Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) DREW MD 3001 South 32. Registraris Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan			nt of He te of De		Mental Hy	/giene Reg. No	2010	38483
	Physicia	an/	1. Decedent's Name (First, Middle, Las	Larry	Sm-	ith				2. Date of Do Month		ly Year	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give	street and number)	Ditt.		4b. Cit	y, Town, or Lo	ocation of Death	12	40	2010 County of Deat	<u> 17:40 ам</u>
200			Gilchrist Cen 5. Social Security Number 6. S		e (les vares de	ant bloth days		owson er 1 Year I	f Under 24 Hrs.	To by the		Balto	
	Funeral Director		220 00 3200	⁹ X M 2 □ F 7. Age	5 <u>4</u>	ast birthday) Yrs.	Months		Hours Min.	8. Date of Bi (Month, Di 12-15	rth a <i>y, Year)</i> 5–19	9. Birt	hplace (State or Foreign untry) MD
	show lat	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation						10d. Inside City Limits
	Maryla 28a-f otifiec	irect	MD	na	Bá	altimo	ore						¥☐ Yes 2 ☐ No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 1814 Maryland	Avenue			10f. Z	ip Code 2120	1		_	tizen of What Co	untry?
	death v items		11. Marital Status	12 Was Decedent F	ver in U.S		Vas Dece	edent of Hispa	anic Origin? (Sp Mexican, Puerto	pecify Yes or No		USA 14. Race - Amer	
036	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates.	No			2 X No 3		7 110411, 010.7		Black, White Specify:	s, etc. Black
2-0	"2 hour "natur edical	Completed	15. Decedent's E (Specify only highest gra	ducation	- 13	(Give k	and of w	ual Occupation	on ing most of wor	king	16b. K	ind of Business I	ndustry
Maryland 21215-0036	within 7 giene. er than the M		Elementary/Seconday (0-12) 8th grade	College (1-4 or 5	i+)			se retired) actor	•	J	Ì	IN KA	JOWN
bue	e filed ortal Hyg ed oth event,	To Be	17. Father's Name (First, Middle, Last)					18		ne (First, Middle			0 0 0
ar Z	2 should be file th and Mental I 27 is marked o traumatic eve		Allen Wright 19a. Informant's Name/Relationship (Ti	/pe. Print)		19h Mailin	a Addres	s (Street and		ice Bi		S Town, State, Zip	Cadal
ž			Betty Edison-S	, . ,		1	-	*	le Ave		alto	, ,	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	C	lace of Dispos emetery, crem	atory or	other place)		Date		ocation - City or	
altir	rmit. Papartme portan y injury		4 ☐ Donation 5 ☐ Other (Specification of Fundamental Service License)		Mt	Zion 22.				8-2010 arch E	Lar ast	nsdown, F/H	MD
m	De La La Co		Dann Mille	**		11:	101	E. No	orth A	venue	Ba.	Lto, MI	21202
	-nysician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused ne cause on each line	the death			- 0			rest,		Approximate Interval Between Onset and Death
م م	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	a consequ		CK-6	211116	a/L	1mb	Jan	Da	weeks
	LAGITITIE	ier	Sequentially list conditions if any, leading to immediate	Due to (or as a	consequ	ence of):							
۸.	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C									
,	certificate be executed inding physician and use as the burial-transit	al E	resulting in death) Last	Due to (or as a	a consequ	ence of):							
3/60	ificate ig phys as the	Medical	IF FEMALE:	d									
Box 68	ath cert attendir for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 1 4 Pregnant at	2 🗌 Fetal	Ideath 3 🗌		pregnancy				23d. Date of deli Month	very Day Year
j Ž	the dea	hysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 Unknown	time or a	eatii 5 🗆	Other (s	pecity)					Day Ioai
7.	es that signed be det	by	Part II. Other significant conditions co	ontributing to death bu	ut not resu	ılting in the ur	nderlying	cause given	in Part I.				the cause of death?
ords	v requir s been s should	oletec	HTV							24a. Was			opsy findings available
Hecords,	The lav ate has page 2	Completed								auto perfo 1 \sum Yes	psy ormed? 2 No	prior to c	ompletion of cause of
ца	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:				Other:	of Death (Chec	k only one)			morrend
от Vital	ng Phy: ter this neral d	te: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 ∐ Inpatie 28a. Date of injur (Month, Day,	у	ER/Outpatient 28b. Time of injury		28c. Injury at work?		ome 5 Resident		Other (Special occurred	W HESPIES
Slon	uttendii death. ctor: Ai y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				M ot factor	1 🗆 Yes	2 □ No	201 1 1' 4			
DIVISION	To the Hospital or Attending Physician: The law requires that the death certific within 24 hourst dired ceath. Within 24 hourst Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as		4 Homicide determined	building, etc.		ne, rann, sue	et, lactor	y, office		City or Tov		d Number or Rura	ai Houte Number,
	Hospi 24 hou Funer eted fill	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examin	ner: On the basis of ex	amination	and/or investig	gation, in	my opinion, d	leath occurred a	t the time date a	and place	and due to the co	usa(s) and manner stated
	To the within To the compl	_ (only one) 3 Certifying Nurs 29b. Signature and title of certifier				20	n Linanaa nu	mak e s		00 0		5 1/ 1
	,		of, can	P				12/2	580	5	12	2-2-	2010
	\		30. Name and address of person who c	ompleted cause of de	eath (Item :	23a) (Type, Pr	int)	tnox.	cen als	15 VL	N.	muer	A, CHAP
	Stat Registra	е	31. Date filed (Month, Day, Year) DEC 0 8 2010	32. Registrar	r's Signatt	ire harke	,				, ,		

Physician/ Medical **Examiner** 21. Signature of Juneral Service Licensee

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f shov Examiner must be notified at

anding physician use as the burial use ō ed by the ours after death.

leral Director: Af
filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

	1 Xomes	M00982	933 Gist Ave. Si	lver Spr	ing, Marylar	nd 20910
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardi	ac or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Respiratory Fai	lure			Onset and Death
	resulting in death)	Due to (or as a consequence of):				
_	Sequentially list conditions, b.	Inanition				
i i	if any, leading to immediate	Due to (or as a consequence of):				
xan	Cause (Disease or iinjury that initiated events c.					
E E	resulting in death) Last	Due to (or as a consequence of):				
<u>ö</u>	d.					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
ed by Pt	Part II. Other significant conditions cont	tributing to death but not resulting in th	ne underlying cause given in Part !.		tobacco use contribute to	
omplet				perf	opsy prior to death?	topsy findings available completion of cause of
Be C	25. Was case referred to medical		26. Place of Death (Cl		2 🔀 🗴 1 □ Yes	S 2 LJ NO
To B	examiner? 1 Yes 2 No	ospital:	Other:		idence 6 Other (Spec	:6.1
Certificate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injur	e of 28c. Injury at		how injury occurred	ary)
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Ru wn, State)	ral Route Number,
Medical	(Check 2 Medical Examine	ian: To the best of my knowledge, dea r: On the basis of examination and/or in Practioner: To the bast of my knowledge	vestigation, in my opinion, death occurre	d at the time, date	and place, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier	2 00	29c. License number		29d. Date signed (Month	n, Day, Year)

D25348

15020 Shady Grove Rd. Suite 300 Rockville, MD 20850

22. Name and Address of Facility Rapp Funeral & Cremation Service

December 3, 2010

State Registrar DHMH 17 Rev 7/2009

24 hours within 24 hot To the Fune completed fil

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcia P. Goldmark, M.D.

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Zora I. Skinner 1:10 pm M 11 24 -2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Ft, Washington Hospital Ft. Washington Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🖾 F Months Days Hours Min 214-76-2125 54 10-13-1956 Virginia Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1. XiYes 2. □ No MD Prince George"s Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8012 Murray Hill Dr. 20744 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Daycare provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. Giles Mildred Fitzhugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Skinner - Husband 8012 Murray Hill Dr., Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Hope 12/4/2010 Front Royal, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 610 W. MacPhail Rd. Bel Air, MD 21014 Nove 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant regnancy Month Day pecify) ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeer? 1 □ Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

Physician /Medical Examiner

executed

Division of Vital Records, P.O. Box 68760, or Attending Physician; The law requires that the death certificate be **Physician**

/Medical

Examiner

Funeral

Director

28a-f show

death with

72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event."

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Exami

Physician/Medical

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Completed

Be

Certification: To

Medical

ed other than "natural", or items 23a or 28a-f show event, the Madical Experience must be notified at

burial-trar the attending signed by the a page this

in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant at time of death	5 Other (sp
Part II. Other significant conditions	contributing to death but not resulting in t	he underlying c

26 Place of Death (Check only one)

examiner?	_						1 1000 01 200	an Johoda Chiy Choy
1 Yes 2 No	Ho	ospital: 🌈	anpatient 2□	ER/Outpatient	3 □ 0	OOA Other: 4	☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
2 Accident	Pending investigation Could not be	(Mo	ate of Injury lonth, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how injury occurred
4 ☐ Homicide		buil	ice of Injury - At ho Ilding, etc. (Specif	y)	, iacto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amir Mirza-Alikhani, MD 11711 Livingston Rd., Ft. Washington, MD 20744

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

after death. the

within 2

filled in by 24 hours a Funeral I Hospital

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	tate of Mary		artment e rtificate			, ,	iene Reg. No. () (38486
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James T. Schilpp						2. Date of Deat 1 2 - 03 - 2		3. Time of Death 1100 P M
	Examin		4a. Facility Name (if not institution, give street 2402 Whitt Rd	t and number)			wn, or Locat			4c. County of D	
	Funeral Director		5. Social Security Number 216-20-4313 6. Sex 1 X M	2 🗆 F	yrs. last birthday) 84 Yrs.	If Under 1 Months D	Year If Un Days Hou	rs Min.	8. Date of Birth 0/1-29-		Birthplace (State or Foreign Country) MD
	aryland ta-f show ified at	ector	Usual Residence of Decedent 10a. State	100	c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N 23a or 26 ist be not	Funeral Director	10e. Street and Number 2402 Whitt Rd			10f. Zip Co	ode 21087			10g. Citizen of What	Country?
9036	Should be filed within 72 hours after death with the Maryland hand Mental Hygiene. I is marked other than "hatural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by Fun	1 Never Married 2 Married	Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No f Yes, Give Year or Dates.		Was Decedent If Yes, specify			ocify Yes or No- Rican, etc.)		
Maryland 21215-0036	within 72 hou /giene. ner than "natu t, the Medica	e Completed by	15. Decedent's Educati (Specify only highest grade of Elementary/Seconday (0-12)	(Give	dent's Usual C kind of work a O NOT use re Inic	done durina r	nost of worki	ng	16b. Kind of Busine	ess Industry	
yland	ild be filed Mental Hy arked ott atic even	To Be	17. Father's Name (First, Middle, Last) Frederick G. Schilpp)				da Geo		flaiden Surname)	
-	of Tand 2 should be of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, P Jean M. Schilpp (Wi	fe)	2402	Whitt	Rd I		I Route Number,	City or Town, State, 21087	Zip Code)
Baltimore,	Page 1 а ment of H ant: If ite ury or ott		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	ob. Place of Dispo cemetery, crer acred He	natory or othe eart of	Jesus	s12-07	-2010 E	20c.Location - City Baltimore	, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		1	.116 010	W. PI	acriiai	r va per	AII, MD	ome of BelAir 21014
~ !	Physician/ Medical Examiner	er	23a. Part. Enter the disease, or complication shock, or heart failure. List only one can Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	use on each line.	evence of):					Coince	Approximate Interval Between Onset and Death
00	cate be executed physician and the burial-transit	dical Examiner	if any, leading to instructiate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last								
. Box 68/6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months?	f yes, outcome of pr 	Fetal death 3	Ectopic preç Other (speci				23d. Date of Month	delivery Day Year
ds, P.O	fuires that the signed by all die deta	þ	Part II. Other significant conditions contribu	uting to death but no	t resulting in the u	inderlying cau	ise given in F	Part I.		1	e to the cause of death?
Division of Vital Records,	The law rec cate has bec page 2 sho	Completed							24a. Was ar autops perform 1 🗆 Yes	y prior ne d? death	autopsy findings available to completion of cause of 1? Yes 2 🏻 No
ITa	sician: certific rector,	Be c	25. Was case referred to medical examiner? 1 Yes No Hospi	ital:			Othor	Death (Check	- 1		
N OT V	iding Phys th. After this funeral di	cate: To		1 □ Inpatient 2 8a. Date of injury (Month, Day, Yea	2 ER/Outpatier 28b. Time of injury	28c.	Injury at work?			nce 6 Other (Sp w injury occurred	pecify)
DIVISIO	tal or Atter rs after dea al Director ed in by the	Il Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, str ecify)	eet, factory, of	ffice		28f. Location (Sti City or Town		Rural Route Number,
	the Hospi nin 24 hou the Funer npleted fill	Medical	only one) 3 Certifying Nurse Pra	On the basis of examin	nation and/or invest	tigation, in my death occurred	opinion, deat at the time,	th occurred at date and plac	the time, date and	d place, and due to t	he cause(s) and manner stated.
	vit CO CO		29b. Signature and the of certifier		4/11/	29c. Li	548	841	2	9d. Date signed/(Mc	
_			30. Name and address of person who complete ASHKA	N BA	HRAN	Print) GC	25	ATT	acon	Ro Ba	AZONTO
	Stat Registra		31. Data filed (Month, Day, Year)	32. Registrar's S	ignature /	arkel	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary				d Mental Hyg	iene	20107
			Registrar	Cer	tificate of L	Death	R	leg. No.	3848/
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	0.1.1			2. Date of Deat Month		3. Time of Death
	Medic		Helena A.	Smith				r 6°, 2010°	1:50P M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o		eath	4c. County of De	
4000			Genesis Eldercare		Brookly			Anne Ar	undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In 1 ☐ M 2 ☒ F	yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth	Yeard 2 /4 9. B	irthplace (State or Foreign ountry) WV •
	Director		Usual Residence of Decedent	OO HS.			pury 17	,1924	WV.
	nd how at	'n		c. City, Town or Loc	cation				10d. Inside City Limits
	aryla: a-fs fied	ecto	MD Anne Arundel	Glen Bur	nia				1 🏿 Yes 2 □ No
	or 28	Dir	10e. Street and Number	GIEN Dar	10f. Zip Code			10g. Citizen of What C	ļ
	ith th	Funeral Director	16 Magnalia Ava		21061			USA	ountry:
	ath w	nue	16 Magnolia Ave 11. Marital Status 12. Was Decedent Ever	in U.S. 13 V		ispanic Origin?	? (Specify Yes or No-	14. Race - Am	eorican Indian
' O	or ite	by F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		Yes, specify Cuba	ın, Mexican, Pu	uerto Rican, etc.)	Black, Wh	
ဗ္ဗ	s afte al", Exar	d b	3 x Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2X☐ No	Specify:		Specify: W	nite
Ö	hour natu lical	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of Busines	s Industry
75	n 72 e. an "l	E G	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)		rind of work done of NOT use retired)	during most of	working	_	
21	withi giene er th , the		12	Acc	ountant			Brokerage	e Firm
b	filed al Hy d oth	Be (17. Father's Name (First, Middle, Last)				Name (First, Middle, M		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	Harry A Alderton			Myrtl	e M Bailey	7	
lar	shoul and is m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street		r Rural Route Number,		ip Code)
≥.	nd 2 ealth m 27 eer tr		Mr. Brian Smith / Son	16 M	agnolia A	Ave Gl	en Burnie,	, MD 21061	
ore	of H of H if iten		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 2	Ob. Place of Dispos cemetery, crem	sition (Name of natory or other plac	;e) 12	Date 7	20c. Location - City of	or Town, State
Ě	Pagi ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specify)	Atlantic	Cremator	y 2	2010	Glen Burn	
alt	sparti sparti port y inj		21. Sign Are of SuA ral A vice Licensee				Singleton I		
	205 20	85 (8	M01220) Se	rvices,	PA 1 2n	nd Ave SW C	Glen Burni	e, MD 21061
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dyin	g, such as card	diac or respiratory arre	st,	Approximate Interval Between
-	Physician/	1 3	Immediate Cause (Final	monie	4				Onset and Death
	Medical		resulting in death) a. Due to (or as a cor	nsequence of):					
	Examiner	L	Sequentially list conditions, b. End	Sta	ee d	emer	AtrA		
	_ +	Examiner	If any, leading to immediate Due to (or as a concause. Enter Underlying	(sequence city)	1				
	cuted	xan	Cause (Disease or iinjury that initiated events c.						
	e exe	ᄪ	resulting in death) Last Due to (or as a cor	isequence of):					}
9	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d						
Box 687	ath certifica attending p	Physician/Me	IF FEMALE:						
×	th ce	ian	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnand	у		23d. Date of d Month	elivery Day Year
ĕ	e dea the a	ysic	in the past 12 months? 1 Yes 2 SNo 4 Pregnant at tim 9 Unknown 9 Unknown	e or death 5 ∟	Other (specify)			Workin	Day Tour
P.O.	at the	H.	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e, Did tob	pacco use contribute t	to the cause of death?
Ψ.	requires that the de been signed by the should be detached	d by							Probably 4 Dunknown
ğ	requii	ete							
တ္ထ	has he le 2 s	Completed					— 24a. Was ar autops	y prior to	utopsy findings available completion of cause of
ď	Physician: The law this certificate has ral director, page 2 :		05 W		***				es 2 🗆 No
<u>ig</u>	ician certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Innetient		Oth		Check only one)		
<u></u>	Phys this ral di	2	27. Manner of Death 28a. Date of injury	2 ER/Outpatien	t 3 🗆 DOA 28c. Injun	4 Cl Nursin	ng Home 5 Reside	nce 6 Other (Spe w injury occurred	cify)
0 0	ding h. After fune	Certificate:	1 № Natural 5 ☐ Pending (Month, Day, Yea		work		1	w Injury occurred	
sio	Attendi death ctor; A y the fi	ŧ	3 Suicide 6 Could not be	At home, farm, stre		100 2 2 110		reet and Number or R	ural Boute Number
Division of Vital Records,	pital or Attending Pours after death. eral Director; After t	Se	4 Homicide determined 2009. Flace of Injury - building, etc. (Sp		•·, ·,,		City or Town		ara riodio riomoci,
	Hospital	ical	29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death o	ccured at the time	, date and plac	e, and due to the caus	se(s) and manner as s	tated.
	n 24 h	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best	nation and/or investi	gation, in my opinio	on, death occurr	red at the time, date and	d place, and due to the	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	-	29b. Signature and title of certifier		29c. License			9d. Date signed (Mon	
			→ (2)(.	MP	1	5346	2_	12/7/0	
			30. Name and address of person who completed cause of death			3 3 10		- (. , .)	21061
			JUNE MUNEYER MD. 78	3 74	AKwa	d 2	10 bac	en Bury	
	Stat	е	31. Date filed (Morith, Day, Year) DEC 0 8 2010 32. Pigistrar's S	ignature	add				
	Registra	ır	DEC 08 2010 Asima	P. A	Merce				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6, 2010 2:40 A Ade1e Stafford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Owings Mills 325 Lantana Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M**XX** F April 22, 1925 85 Italy Director 212-28-5681 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Id be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits Director MD Baltimore Randallstown 1 Yes XX No 10e. Street and Number 10g. Citizen of What Country? Funeral 9073 Meadow Heights Rd. 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Force Completed by I 1 Never Married 2 Married 1 ☐ Yes **②X**No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: White marked other than "natural", XX Widowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdressing 8 Hairdresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Rosa Salinitro permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Francesco Pipitone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, MD 21117 Joan Dayton / Daughter 325 Lantana Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cemetery, crematory or other place)
Lake View Memoria1
Park 1 Burial 2 Cremation 3 Removal from State 12/10/10 Sykesville, MD 4 Donation XX Other (Specify) Entombmen 21. Signature of Seal Seal Ce License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ Metastahu colon concer disease or condition resulting in death) tyens Medical Due to (or as a consequence of) Examiner Metastri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an this certificate has ral director, page 2 autopsy death?
1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After Natural Accident injury 5 Pending Investigation 24 hours after deatle Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 😂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Sig 29d. Date signed (Month. Day, Year, 175044 2010 on who completed cause of death (Item 23a) (Type, Print) brHarm ate Drive Baltimae NO 21209 MO 31. Date filed (Month, Day, 32. Registra s Signature State DEC 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Physician/ 1730 M 2010 RNARD HERR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months Hours Min 0970271928 82 MD Director 219-22-4668 Usual Residence of Decedent or 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** Page 1 and 2 should be filed within 72 hours after death with the Maryland 1 ☐ Yes 2 ☐XNo MD ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 117 OAKFORD AVENUE 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. Completed by 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", 3 X Widowed 4 □ Divorced Specify. WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **PHOTOGRAPHER** PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည SAMUEL **SCHERR** LILLIAN LEVITSKY and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 MARY WHEELER/DAUGHTER 117 OAKFORD AVENUE, EDGEWATER, MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH YEHUDA ANSHE KURLAND CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State
 Departion 5 ☐ Other (Specific) Department of Important: If it any injury or o Donation 5 Other (Specify) 12/7/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of uneral Service Lidenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the diseas and complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SDI PATOR Physician/ Medical resulting in death) as a consequence of Examiner DIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗆 No 1 Tyes To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_ Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 3 U Suicide 4 U Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ompleted ca use of death (Item 23a) (Type, Print) EFFINSE HWY ANNAPAIS MDZIYU 32. Regi State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day RINA Zo Year 6 15 Medical 4a. Facility Name (if not institution, give street and num Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex Age (In vrs. last birthday If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) UKRAINE 1 □ M 2 ⋤ F Months Days Hours Min 0470871934 Director 214-59-8823 76 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 6974 MILLBROOK PARK DRIVE, #2C 21215 USA 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Divorced 4 Divorced Specify. WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT FINANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ISAAK SCHLEONSKIY MARIYA **TAYETS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONID SUKHOY/HUSBAND 6974 MILLBROOK PARK DR, #2C, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 12/7/2010 REISTERSTOWN, MD 21. Signature Funer I Pervice License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ww 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse ence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Q after death.

• Director: After this certificate has been signing by the funeral director, page 2 should t Completed 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 100 2 No Other: 1 Tes ၉ 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident□ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after
To the Funeral Directory Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ertifier completed cause

Registrar

State

31. Date filed (Month, Day, Year

08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 3 2010 ar GERTRUDE SILVER 9:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 063-12-3305 90 Country) 1/29/239/1919 NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner more to a concerning the control of the co 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY SILVER SPRING 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 3700 INTERNATIONAL DRIVE 20906 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 X Widowed 4 □ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL WORKER CITY OF NEW YORK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ TURIN SAMUEL MAX HELEN GESTERN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED HABER / NEPHEW 188 BUCKINGHAM ROAD TENAFLY, NJ 07670 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State MT. MORIAH CEMETERY 12/3/2010 FAIRVIEW, NJ 4 Donation 5 Other (Specify) Signature of Funeral Service Ac 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MyoLANDIAL Physician/ disease or condition Medical resulting in death) Due of (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate the burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as 1 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Vear Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Procuminia Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ge 2 should ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No a 24 hours after death.

Funeral Director: After this certifica leted filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKTITUR PRINCE Philip DR OLNEL SCHOENGOLD, MD 18101 31. Date filed (Month, Day, Year)
DEC 0 8 2010 32. Registrar's Signature State acke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death mith Physician/ Month 35 ari Promber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lizaketh cursing al TIMOY Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday If Under Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** 1 🗆 M 2 💢 Months AUGUST 15, Yrs. Director 73 213,34,8496 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 XX Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 BENSON AVE 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 □ Divorced WHITE Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TAX ACCOUNTANT 12 2 ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ANNE CATHERINE HICKMAN OLIVER EMERSON THIESSEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 408 LAUREL DR. SEVERNA PARK, MD 21146 BOB SMITH 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★★Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) **NEW CATHEDRAL CEMETERY** 12.8.2010 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ²²FYNK FUNERAL HOME, P.A. K. GREGORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ emen disease or condition Medical resulting in death) sequence of): Due to (or as a c **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a com equence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 L Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 2 🗌 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 15enson W

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 25 ay 2010 Year 1122AM FRANKLIN CHARLES SANDERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1525 MATTHEWSTOWN RD. HANOVER ANNE ARUNDEL 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Days Hours Min JUNE 28. 55 Director 212.62.6954 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2xx No MD ANNE ARUNDEL **HANOVER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 MATTHEWSTOWN RD. 21076 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 I If Yes, Give Year or Dates. ^{2 □ No} 1972-74 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LOCAL 101 **CARPENTER** 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ JOHANNA EBINER JACK SANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1525 MATTHEWSTOWN RD HANOVER, MD 21076 WIFE SHARON SANDERS 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or of once. cemetery, crematory or other place, 1 Burial 2 KCremation 3 Removal from State BAYVIEW CREMATORY INC NOV 27, 2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Sign wife of Funeral Service Linensee FINK FUNERAL SHOME ILITYP.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 CRECORY FINK M01148 K disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, a heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hrouse Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 performed? this certificate 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 XXNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home STA Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at s after death. I Director: After t Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury **XX**Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **NOVEMBER 27, 2010** D06054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM JONES 6131 SHADYSIDE RD. SHADYSIDE MD 20764 MD DEPUTY

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year urner 6:10AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min Director ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location Baltimore 10d. Inside City Limits Completed by Funeral Director 1 ¥ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced lack 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ဥ Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, 175*u* 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Se Vice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANGREATIC Physician/ CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to or as a consequence of attending physician and for use as the burial-tran-Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe HYPERLIPIDEMIA 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) 2 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔲 Yes 2 🗔 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 12-3-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MD B140 SPERLING M.D 5601 LOCH

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State Registr<u>ar</u> 31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pamela Tcherkassky Rose December 2, 201^r0^{ar} 6:09 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 13505 Magruder Farm Ct. Potomac 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Months Hours Min 63 Maryland 220-48-2780 Director Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 13505 Magruder Farm Ct. United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Public Education Teacher Be Department of Health and Mental h Important: If item 27 is marked on any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Stephens Josephine Diomede 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Viers Mill Rd., Rockville, MD Alexis M. Tcherkassky / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Chesapeake Crematory 12/6/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Ser MOO 382 Rapp Funeral and Cremation Services Hollmen 20910 Gist Ave., Silver Spring, MD 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 4 years Immediate Cause (Final Pnysician/ Squamous Cell Carcinoma of Head & Neck disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consuluence of It any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death a ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 XNo 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22775 December 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Center Dr., #210, Silver Spring, MD 20902 Barr M.D. Frederick G. 31. Date filed (Month, Day, Year) Registrar's Signature

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **December** 20°10 4:30 Рм Joseph P. Tribull Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Nottingham 8900 Danshire Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Maryland 1 🛛 M 2 🗆 F Hours 09-25-1824ar) 86 Director 217-12-8157 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director r 28a-f st notified a 1 Yes 2 X No Nottingham Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21236 USA 8900 Danshire Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 No Completed by 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced WII Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T Communications Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Flizabeth Prosch Herman Tribull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8900 Danshire Road Nottingham, Maryland 21236 Mrs. Alice S. Tribull - Wife Department of Health Important; If item 27 any injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12-6-2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or con plic mons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one vause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disease or condition Baltimore, Maryland 21214 Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): bronchisconsus 12025 Examiner 10 Monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

Me Tax Tax Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Seare Osteoarthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\text{Residence} \) Residence 6 \(\sum \) Other (Specify) ည 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d Describe how injury occurred 1 X Natural 5 Pending NA Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 127701/2010 Albert VanKeuren 2135 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Sex 1 🕅 M 2 🗌 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1/2/11/7/11/925 138-20-4254 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 🗌 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 Inglewood Rd 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than "
traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) Sales Manager Electrical Products Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor VanKeuren Ethel Nytray je 1 and 2 should by t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Inglewood Rd Mary VanKeuren (Wife) Important: If item 27 any injury or other tra Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 12-06-2010 Baltimore, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Secuentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Jue to (or as a con: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown this certificate has been signed by the arral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dimpatient 2 D ER/Outpatient 3 DOA 27. Man 🥜 of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicum: It the cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, deeth of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

2/1001

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF, 6910, 12/13/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Viola Frances Wellons Month Year 30 pM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Envoy Nursing Home Pikesville Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 M 2 F Months Director 212-16-3541 94 6 191 Tune Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland N/A X 1 ☐ Yes 2 ☐ No Baltimore 10e, Street and Number 10f. Zip Code 21215 Funeral 10g. Citizen of What Country? 5118 Levindale Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 X No Specify: Black 3 Widowed 4 Divorced 1 ☐ Yes 2 ☑ No Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Maid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sabella Jones ည Walter Brown 19a phormant's Name/Relationship (Type, Print)
Pernell Brown/ Sor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5118 Levindale Road Baltimore, Mary Land 21215 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1.8
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State 12/10/10 4 Donation 5 Other (Specify) King Memorial Park Woodlawn, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 23a. Par . Enter the diseasck, or heart failur . or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Immediate Cause (Fin disease or condition resulting in death) Interval Between Physician/ Onset and Death Menghary Medical 10915 Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause Cause (Disease or iinjury that initiodaese or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? autopsy 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🕽 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 9105, Touson MD 21204 6701 Charles ST 31. Date filed (Month, Day, Year) 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $0^{ extstyle Day}_{4}$ 20 ใ Whelchel 8:35p.M Tommie James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Future Care Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**火** M 2 □ F (Month, Day, Months Days Hours Min. Country) Director 219-38-2848 68 GA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U.S.A. 1513 Lochwood Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify: Specify: Black ¥☐ Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I th and Mental Hygiene. ?7 is marked other than "r Johns Hopkins Hosp. Elementary/Seconday (0-12) College (1-4 or 5+) the 5+yrs Rehabilitation Center Social Worker 2th grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 L. Whelchel Elizabeth Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other tra. 513 Lochwood Road, Baltimore, Md 21218 <u> Elizabeth Tolson-Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 12/14/2010 Owings Mills, Md 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or comple cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown g 🗌 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has e autopsy performed Yes 2 this certificate har ral director, page 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tammuch Date filed (Month, Day, Year) DEC 0 8 2010 32. Registrar's Signature Registrar

DECEMBER 5, 2010 8:00 p.m.

Division of Vital Records, P.O. Box 68

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	Physicia		1. Decedent's Name (First, Middle, Last) Kathleen K.		White			2. Date of Death Month	r ^{Day} , 2010	3. Time of Death 8:00 P M	
	Medic Examin		4a. Facility Name (if not institution, give street and nu	mber)		4b. City, Town, o	r Location of Death	Decaribe	4c. County of Deat	n	
Mar. 05			Stella Maris Hospice 5. Social Security Number 6. Sex	7 1 ()	A fe findle along A	Towson Baltimore If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birtholace (State or Foreign)					
	Funeral Director	123	220-24-6006 Usual Residence of Decedent	7. Age (In yrs. las		Months Days	Hours Min.	8. Date of Birth (Month, Day, December	7, 1926 Wes	hplace (State or Foreign Intry) Virginia	
	Maryland 28a-f shov otified at	rector	10a. State 10b. County Maryland Baltimore	10c. City,	Town or Loc Dun	cation dalk				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo	
į	s 23a or 2 nust be no	Funeral Director	10e. Street and Number 3005 Liberty Parkway			10f. Zip Code 212.	22	11	ng. Citizen of What CoUSA	untry?	
9200	permit. Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If fire AZ is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Armed F	: 2 ∑X No ive	"	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.	
Maryland 21215-0036	within 72 hou giene. er than "nat , the Medica	Completed by	15. Decedent's Education (Specify only highest grade complete) Elementary/Seconday (0-12) College 12 years	ng	16b. Kind of Business Baltimore Public Sc	County					
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, Mar	nd z shou lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Type, Print) Ellen Smith Daugh		1776	Langpor			City or Town, State, Zip , Maryland		
Baltimore,	rage la ment of H tant; If ite iury or otf		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	m State cer	metery, crem adowri		9,	2010	20c. Location - City or Elkridge,	Maryland	
Balt	Depart Depart Import any inj		21. Signature of Funeral Service Licensee	M01176	²² C 7	Name and Addre onnelly 110 Soll	ss of Facility Funeral Ho ers Point	ome Of D Road, D	undalk,P.A undalk,Md.	°21222	
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£12.	cian and urial-transit	Examiner	if any, leading to immediate cause. Enter I Inderlying Cause (Disease or iinjury that initiated events c.	o (or as a conseque	,						
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Box 68760 &	the attending physic ched for use as the bu		in the past 12 months?	utcome of pregnance Birth 2 Fetal of gnant at time of dea	death 3 🗌	Ectopic pregnand Other (specify)	ey		23d. Date of del Month	ivery Day Year	
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Division of Vital Records, P.O.	ate has been sig	Completed by						24a. Was an autopsy perform	/ prior to d	opsy findings available completion of cause of	
ital	certific ector,	B B	25. Was case referred to medical examiner?			Oth	ace of Death (Check				
n of V	h. After this funeral di	ate: To	27. Manner of Death 1 Natural 5 □ Pending (Mo.	Inpatient 2 Ele of injury enth, Day, Year)	R/Outpatien 8b. Time of injury	28c. Injur	4 ∐ Nursing Hor y at 2	me 5 Resider 28d. Describe hov	nce 6X Other (Speci v injury occurred	M HOSPICE	
ivisio	i g ig	Certificate:		e of Injury - At hom ling, etc. (Specify)	e, farm, stre			28f. Location (Stre Cify or Town,	eet and Number or Rui State)	al Route Number,	
Hospita	n 24 hours ne Funeral pleted filled	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 3 X Certifying Nurse Practioner	asis of examination a	and/or investi	gation, in my opinio	on, death occurred at	the time, date and	place, and due to the o	ause(s) and manner stated.	
\$ E	with To tl		29b. Signature and title of certifier	of		29c. License	number 19792	29	ld. Date signed (Month	, Day, Year)	
	a		30. Name and address of person who completed cau	se of death (Item 2		,	TIMONIUM	MD 210			
	Stat Registra	te ar	DEC 0 8 2010 Server 32.	Registrar's Signatur	gles			9 110 41 6			